Continuum Reproductive Center
425 West 59th Street Ste. 5A
New York, New York 10019
Phone: (212) 523-7751
Fax: (212) 523-8348
www.InfertilitySpecialistNewYork.com

Making an Appointment at the Continuum Reproductive Center

Business Hours: 9 am-5 pm, Monday-Friday

Office number: (212) 523-7751
Fax number: (212) 523-8348

When You Call for Your First Appointment

Please provide our staff with the following information:

- Full Name
- Telephone numbers (home, work and cellular)
- Name of your referring physician (if you have one)
- Insurance information (please indicate if HMO or PPO plan)

Preparing for Your First Appointment

Please bring the following information (if applicable):

- A referral from your referring physician (if needed)
- Your prior medical records including:
- Office notes
- Laboratory results
- X-ray and/or ultrasound reports
- Operative reports

Regarding Costs and Insurance Coverage

If you wish, before your first appointment check with your insurance carrier for the details of your healthcare coverage. Once you are in our care, we will contact your carrier directly.

To get started, schedule an initial consultation with us by calling 212-523-7751. Describe your insurance to the staff member, and she will let you know whether or not the visit will be covered.

The CRC is dedicated to providing high-quality, state-of-the-art fertility services not only to those of significant financial means, but also to those who require insurance to pay for these services. For more information, visit Financial Information.

Directions to the Continuum Reproductive Center

Continuum Reproductive Center
425 West 59th Street (Suite 5A)
New York, New York 10019

We are located on West 59th Street between 9th Ave (Columbus Avenue) and 10th Avenue (Amsterdam Ave).

By Car:

From the Lincoln Tunnel: Follow signs to the West Side Highway. Make a left on West 42nd Street and a right onto 10th Avenue. Make a right onto West 60th Street and another right onto 9th Avenue. Make the first right onto West 59th Street (you will find two parking lots on this street).

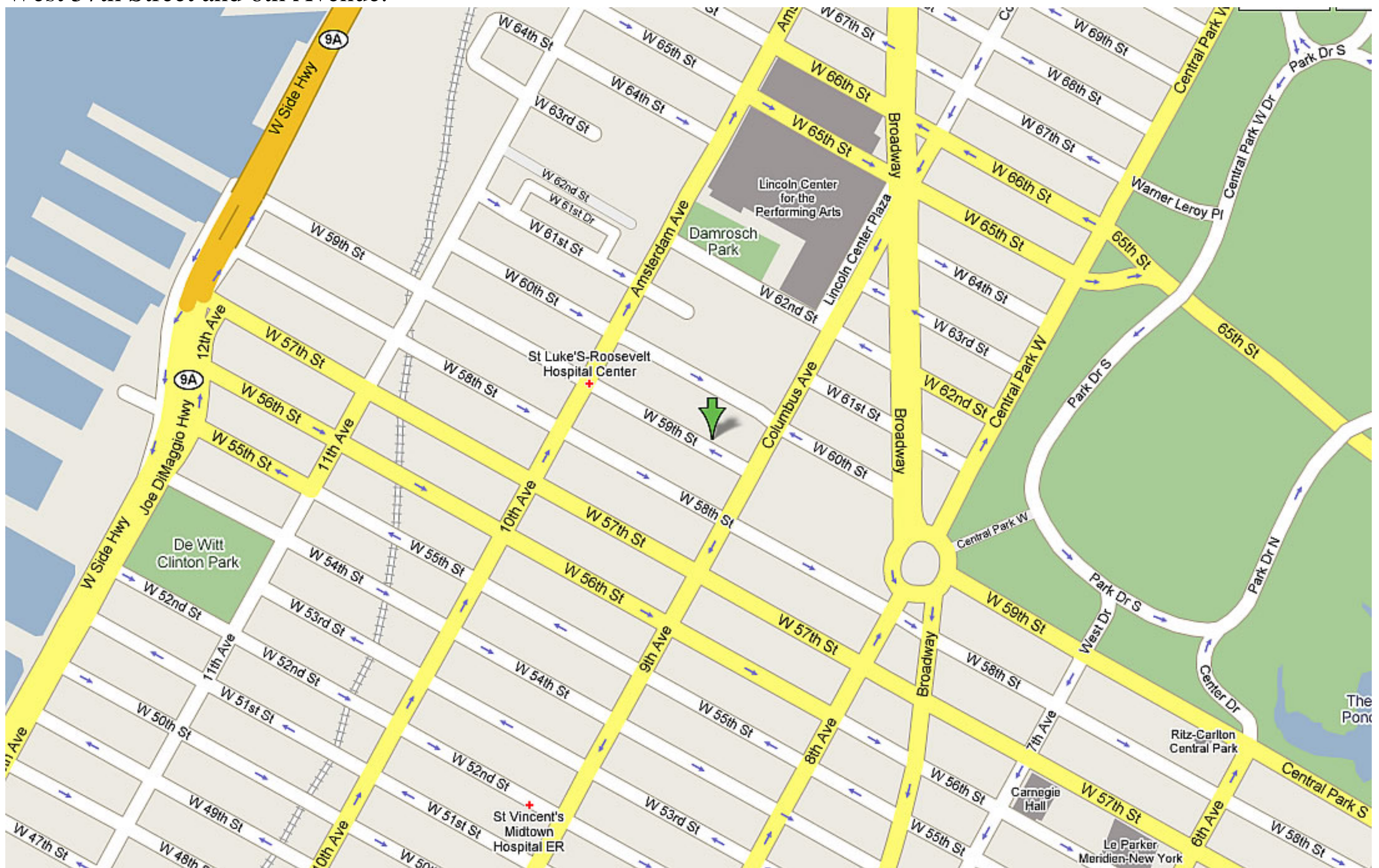
From the George Washington Bridge and points north:

Take the West Side Highway south and exit at West 56th Street. Head north on 10th Avenue. Make a right onto West 60th Street and another right onto 9th Avenue. Make the first right onto West 59th Street (you will find 2 parking lots on this street).

From Brooklyn:

Take the Brooklyn Bridge or Battery Tunnel and head north on the West Side Highway. Exit at West 56th Street and head north on 10th Avenue. Make a right onto West 60th Street and another right onto 9th Avenue. Make the first right onto West 59th Street (you will find 2 parking lots on this street).

By Subway:
The B, Q and D and #1 train lines stop at the 59th Street/ Columbus Circle Station. The N, R and W train lines stop at West 57th Street and 6th Avenue.



PATIENT QUESTIONNAIRE

Division of Reproductive Endocrinology St. Luke's-Roosevelt Hospital Center
Martin D. Keltz, M.D. Daniel E. Stein, M.D.

This questionnaire provides your physician(s) with medical information which will help him to formulate an appropriate medical plan. The included information is part of your medical record and is confidential.

Full Name ______________________________ Date ____________ Age______ Birthdate______________
Address ____ Home Telephone ( )________________
Occupation ________________ Employer__________________ Work Telephone ( )_______________

Name of Spouse or Partner (if applicable) _______________________________________
Telephone number of Spouse or Partner ( )________________________________

Referring Physician: Full Name ________________________________ Specialty______________________
Address _____________________________ Telephone ( )______________

Please describe the reason(s) for today's visit and any pertinent background information (including previous evaluations, medications used, previous physicians and any previous tests performed):

____
____
____
____
____
____
____
____
____

OBSTETRICAL HISTORY Total number of times you have been pregnant: __________

	Number	Dates (month/year)	Sex (M,F)	Vaginal/C-Section
Full Term Deliveries:	______	________________	_______	________________
(> 37 weeks)		________________	_______	________________
		________________	_______	________________
Premature Deliveries:	______	________________	_______	________________
(< 37 weeks)		________________	_______	________________
		________________	_______	________________

Miscarriages: ______ # weeks pregnant_______ D&C done? (circle Y or N)
Abortions: ______ Stillborns _______ (Provide details below – e.g. cause(s))
Ectopic Pregnancies ______ (Provide details below – e.g. how it (they) were treated)

Please list any complications with any of your pregnancies (including birth defects, stillborns, ectopic pregnancies):

____

Have you ever been advised by a previous physician to avoid pregnancy in the future? ________________
Have you ever been advised by a previous physician to avoid a vaginal delivery in the future? ______________

MENSTRUAL HISTORY First day of Last Period: ____________ Age of first period __________
First day of Prior Period: ____________ # of days you bleed: __________

Typical number of days from first day of bleeding in one cycle to first day of bleeding in next cycle: __________

Do you consider your periods Regular/Irregular? __________ Do you frequently miss periods? __________

Do you bleed: LIGHTLY ____ MODERATELY ____ HEAVILY ____ Do you pass clots? __________

Do you bleed between periods? _____________ Are your periods painful? _________________________

Does the pain precede the period ? _____________ Does the pain end when the period ends ? _____________

SEXUAL HISTORY Are you involved in a sexual relationship?____ Is your partner of a different sex or same sex? ___________

If applicable, please list your frequency of intercourse. _____ times per week _______ times per month

Do you encounter pain, bleeding or other problems before, during or after intercourse? If yes, please describe:

GYNECOLOGY HISTORY List any forms of contraception you have ever used (type(s), duration of use)

Have you had abnormal pap smears in the past? ________ Date & result of last pap smear? _________________

Have you had a colposcopy and/or biopsies performed on your cervix? _____________________________________

Have you ever experienced any breast discharge? (if yes, please describe):___________________________________

Have you or have you ever been infected with any of the following?:

Pelvic Inflammatory Disease (PID) ___________________ Chlamydia ________________________
Gonorrhea ________________________ Syphilis ________________________
Hepatitis B or C ________________________ HIV ________________________

If you answered yes to any of the above, please state when you were diagnosed, how you were treated and if you were hospitalized:

Please List ALL surgeries you have had (include dates and hospitals where the operations occurred):

MEDICAL HISTORY Please list all serious illnesses you have ever suffered from (list dates of all hospitalizations):

____
____
____
____

Please list any and all medications you are presently taking (include doses if possible):

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

Please list and describe any allergies you have to medications:

____________________________________ ____________________________________
____________________________________ ____________________________________

Do you have any allergies to rubber or latex products? ____________________

Do you have any allergies to peanuts or sesame seeds or oils? ____________________

Have you ever had any of the following illnesses or been vaccinated for them?

Rubella (German Measles) ____________________
Measles ____________________
Chicken Pox (Varicella) ____________________
Hepatitis B ____________________

Do you smoke (if yes, how many cigarettes per day and for how many years)? ________________________

Do you drink alcohol (if yes, what kind, how much and how often)? ________________________

Do you use any recreational/illicit drugs (if yes, what kind, how much and how often)? ____________________

Current Height __________ Current Weight __________ Have you had recent weight gain or loss (please describe)?

____

Do you exercise (what type, how often)? ____

Have you experienced significant: hair loss (scalp) ______ hair growth ______ thirst ______ urination ______

PARTNER'S HISTORY (all questions apply only to *male* partners)

Age __________ Date of Birth ____________________

Number of children from this relationship _______ Number of children from another relationship ________

Has partner ever impregnated another woman (what was outcome)? ______________________________

Has partner ever had any medical illnesses, neurological illnesses or sexually transmitted infections (list in detail)?

____
____
____

Has partner had any surgical procedures? (Please describe)

____
____

Is partner on any medications? (Please list)

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

Has partner had a semen analysis performed? (If yes, provide date(s) and results):

Does partner have any difficulties with ejaculation or obtaining and erection? (please desribe)

Has partner ever consulted with a urologist (who? when? for what reason?)

Has partner been recently (within 3 months) exposed to any of the following? (Please describe)

Excessive heat (e.g. ovens, hot tubs, high fevers)

Toxic chemicals (including chemotherapy)

Radiation

Cigarette Smoke

Alcohol

FAMILY HISTORY

List any of the following conditions which may have occurred in a sibling, child, parent, grandparent, parent's sibling or first cousin:

	Patient's Family	**Partner's Family**
Birth defects		
Recurrent miscarriages		
Heart Disease		
Diabetes		
Infertility		
Other		

Ob/Gyn Associates of SLR
Division of Reproductive Endocrinology and Infertility

Reproductive Endocrinology is a highly specialized field which requires extensive testing to achieve favorable results.

Many of the procedures which need to be performed are not routinely reimbursed by insurance coverage.

If you are covered by an HMO or PPO, your coverage will be verified by a staff member. I will inform the staff which procedures need to be performed so that preauthorization for those services can be requested. Many of the procedures which we may consider necessary may not be covered by your plan; therefore, you will be required to pay for such services. A bill will be provided to you so that payment can be made when the service is performed.

If you are covered by a commercial policy, your coverage will be verified by our staff. It is requested that payment be made at the time service is rendered. A receipt sill be generated which you may use for insurance submission. We will gladly submit a claim for you, if you prefer.

Any exceptions to these guidelines must be arranged in advance of treatment.

We welcome the opportunity to participate in your care.

I have read the terms outlined above, and I agree to assume all financial responsibility for procedures which are deemed necessary to my treatment and are performed by OB/GYN Associates of SLR.

_______________________________________ _____________________

Signature Date

_______________________________________ _____________________

Witness Date

Continuum Reproductive Center
Instructions for Collection Of Semen Specimens and/or For Scheduling A Semen Analysis

All semen analyses are performed in the Andrology Laboratory of the Continuum Reproductive Center, at 425 West 59 Street, Suite 5A, NY, NY 10019.

Please call 212-523-7751 for an appointment for your semen analysis. Appointment hours are Monday through Friday from 9:30 am–2:30 pm. Appointments must be made at least two (2) days in advance.

Abstain from ejaculation for 2-5 days prior to the day of the semen analysis. Do not abstain for longer than 5 days.

It is best that semen samples are collected at the CRC. Collect the specimen by manual masturbation into a sterile collection cup, which will be provided to you. Do not use lubricants or ointments as they may interfere with the function of the sperm. Collection of semen by intercourse using a condom or by oral stimulation may yield suboptimal samples and should be avoided. Do not use condoms. Should you need to provide semen by intercourse, i.e., for religious reasons, a special condom will be provided to you or prescribed for you. In such cases, carefully remove the condom immediately after ejaculation and place the condom into a sterile specimen cup.

As mentioned, it is best that samples are collected at the CRC. However, if produced off-site, all of the conditions in the above paragraph should be observed. In addition, the specimen should be brought to the laboratory not more than one hour after ejaculation. Care should be taken to carry the specimen upright and close to the body to avoid exposing it to extreme temperatures. Do not touch the inside of the collection cup as contamination may occur.

Samples will be rejected and will not be analyzed if they do not have the following information on their labels:
Last and first name of man producing the sample
Date of man's birth
Date and time of ejaculation
Spouse or partner's last and first names

All samples must be accompanied by a semen submission form (provided by the CRC) and requisition form signed by the ordering physician.

If a semen sample is to be cryopreserved (frozen) for future use, the man who produced the sample must be present when it is turned in to the lab.

Within five (5) working days of testing, results will be made available to the physician only.

A Kruger, or critical morphology, of the sperm is performed in most semen analyses. It is one of the principal indicators of the ability of the sperm to penetrate an egg. Most insurance carriers do not cover the cost of the critical morphology and a $200 payment is due at the time of the semen analysis. The cost of the basic semen analysis will be billed to the insurance company if the benefit is covered. As a service to those men whose basic semen analysis is not covered by the insurance carrier, the CRC will charge only the $200 for the critical morphology and forego the fee for the basic semen analysis.

If the sperm motility (percentage of moving sperm) is <20%, the laboratory will perform a sperm viability test to determine what percentage of the sperm are viable. This test incurs an additional charge to the patient.

If no sperm are seen in the specimen, a condition called azoospermia, a fructose test will be performed to determine if there is an obstruction in the male reproductive tract. This test incurs an additional charge to the patient.