

Assisted Reproduction Insurance Program®

New Life Agency, Inc. Lloyd's Coverholder
41-750 Rancho Las Palmas Drive • Suite N-3 • Rancho Mirage, CA 92270
Tel (877) 952-5433(LIFE) • Fax (877) 952-5589

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

DATE _____

NAME _____ PARTNER'S NAME _____

ADDRESS _____

TELEPHONE NUMBER: DAY _____ EVENING _____

D.O.B. _____ PARTNER'S D.O.B. _____ DURATION OF RELATIONSHIP _____ DURATION OF INFERTILITY _____

INSURANCE COMPANY _____ INSURANCE ID# _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment – title(s), location, brief description, number of years employed.

Are you or have you ever been exposed to any of the following during employment or military service:

- ! Heat
- ! Toxic Fumes
- ! Other Specify _____
- ! Chemicals
- ! Nuclear Radiation _____

II. MEDICAL HISTORY

YES NO

WEIGHT _____ HEIGHT _____ BLOOD TYPE IF KNOWN _____

HAVE YOU LOST GREATER THAN 20 POUNDS OF WEIGHT IN THE LAST YEAR?.....

DO YOU FOLLOW A PARTICULAR FOOD DIET OR HAVE ANY SPECIAL DIETARY HABITS?..

IF YES, SPECIFY: _____

LIST THE FORMS & FREQUENCY OF REGULAR VIGOROUS EXERCISE (SWIMMING, CYCLING, RUNNING & AGE YOU BEGAN: EXERCISE: _____ HRS/WK _____ AGE _____
EXERCISE; _____ HRS/WK _____ AGE _____

DO YOU FREQUENTLY TAKE SAUNAS OR STEAM BATHS?.....

HAVE YOU EVERY HAD SURGERY IN THE PELVIC AREA?.....

IF YES, SPECIFY DATE & TYPE _____

HAVE YOU EVER RECEIVED X-RAYS IN THE PELVIC AREA FOR THERAPY OR DIAGNOSIS?

IF YES, EXPLAIN _____

Do you have or have you ever had (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Sourness | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Liver Infection | <input type="checkbox"/> Testes Infection |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Testes Injury |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Testes Tumor |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps with Testes Involved | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | |
| <input type="checkbox"/> Any Allergies _____ | | |

YES NO

HAVE YOU EVER BEEN TREATED FOR CANCER?.....
IF YES, EXPLAIN THERAPY _____

WITHIN THE LAST YEAR, HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS?.....
IF YES, LIST ALL PRESCRIPTIONS AND PROBLEMS FOR WHICH YOU WERE TAKING THEM;

ARE YOU TAKING ANY OVER-THE- COUNTER MEDICATIONS ON A REGULAR BASIS?.....
IF YES, LIST ALL MEDICATIONS AND DIAGNOSES: _____

HAVE YOU HAD A HIGH FEVER (OVER 102) DURING THE PAST 3-4 MONTHS?.....

DO YOU OR HAVE YOU EVER USED (CHECK ALL THAT APPLY):

- ALCOHOL: HOW MANY GLASSES PER WK DO YOU USUALLY DRINK? WINE ___ BEER ___ COCKTAIL ___
- CIGARETTES -# PACKS PER DAY _____
- ILLICIT OR RECREATIONAL DRUGS (MARIJUANA, COCAINE, ETC.)

IV. SEXUAL HISTORY

YES NO

ARE YOU CIRCUMCISED?.....

WHEN YOU WERE A CHILD WERE BOTH TESTES DESCENDED INTO THE SCROTUM?.....

AT WHAT AGE DID YOU BEGIN SHAVING REGULARLY OR START TO GROW A BEARD?.....

HOW MANY TIMES HAVE YOU BEEN MARRIED? _____

HAVE YOU EVER PRODUCED A CHILD WITH ANOTHER PARTNER?.....
IF YES HOW LONG DID IT TAKE TO PRODUCE A CHILD? _____ WHEN WAS THIS (DATES) _____

HAVE YOU EVER TRIED TO PRODUCE A CHILD WITH ANOTHER PARTNER?.....

DO YOU HAVE TROUBLE GETTING AN ERECTION?.....

MAINTAINING AN ERECTION?.....

DO YOU HAVE TROUBLE WITH EJACULATIONS?.....

IF YES, PREMATURE EJACULATIONS RETROGRADE EJACULATIONS

DO YOU FEEL THAT SOME OF YOUR EJACULATE IS DEPOSITED IN THE VAGINA?.....

DO YOU EVER HAVE ORGASMS WITHOUT EJACULATION DURING MASTURBATION?.....

DO YOU HAVE ANY DISCHARGE FROM THE PENIS?.....

HOW MANY TIMES PER WEEK DO YOU AND YOUR PARTNER HAVE SEXUAL INTERCOURSE?_____

HOW MANY TIMES DO YOU HAVE INTERCOURSE AROUND OVULATION?_____

HAVE YOU NOTICED A CHANGE IN YOUR SEXUAL DRIVE RECENTLY?.....

V. FAMILY HISTORY

IS THERE A FAMILY HISTORY OF INFERTILITY?.....

IF YES, WHO LIST ALL MEMBERS AND RELATIONSHIPS TO YOU_____

IS THERE HISTORY OF HORMONAL DISORDERS IN YOUR FAMILY?.....

IF YES WHAT TYPE:_____

VI. HISTORY OF FERTILITY THERAPY

HAVE YOU BEEN TREATED FOR INFERTILITY BEFORE?.....

IF YES, WHO WAS YOUR PHYSICIAN?_____

WHAT CAUSE OF INFERTILITY WAS DIAGNOSED?_____

WHAT DRUGS HAVE YOU TAKEN FOR INFERTILITY? CHECK ALL THAT APPLY:

- CLOMIPHENE CITRATE(SEPOPHENE ®,COMID®) hCG (PROFASI ®, A.P.I. ®)
- hMG (PERGONAL®) FLUXYMESTERONE (HALOTESTIN ®)
- TAMOXIFEN GnRH or LHRH (FACTREL ®)
- TESTOLACTONE UROFOLLITROPIN OR FSH (METRODIN®)
- BROMOCRIPTINE (PARLODEL®) OTHER – SPECIFY_____
- TESTOSTERONE OR MALE HORMONE NONE

HAVE YOU EVER HAD VARICOCELE REPAIR?..... YES NO
IF YES SPECIFY DATES_____

HAVE YOU EVER HAD VASECTOMY REVERSAL OR REPAIR?..... YES NO
IF YES SPECIFY DATES_____

HAVE YOU AND YOUR PARTNER EVER TRIED ARTIFICIAL INSEMINATION?..... YES NO
IF YES, USING YOUR SPERM OR DONOR SPERM?_____

HAVE YOU AND YOUR PARTNER EVER TRIED IN VITRO FERTILIZATION?..... YES NO
IF YES, SPECIFY WHEN AND EXPLAIN:_____

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD PERFORMED? CHECK ALL THAT APPLY AND THE

RESULTS IF KNOWN:

- SEMEN ANALYSIS
- CHLAMYDIA TEST
- MYCOPLASMA TEST
- ANTIBODY TEST
- HAMSTER EGG TEST
- CHROMOSOME TEST
- TESTICULAR BIOPSY
- X-RAY OR ULTRASOUND OF TESTES
- HORMONAL TEST (FSH, LH, PROLACTIN, TESTOSTERONE)
- THYROID TESTS
- OTHER – SPECIFY _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

WHEN? _____ RESULTS _____

YES NO

IS YOUR PARTNER SEEING A DOCTOR FOR EVALUATION OF INFERTILITY?.....

IF YES, SPECIFY PHYSICIAN NAME AND LOCATION: _____

DOES THE DOCTOR FEEL THAT YOUR PARTNER HAS AN INFERTILITY PROBLEM?.....

IF YES, WHAT IS THE DIAGNOSIS AND HOW IS HE BEING TREATED? _____

HAS SHE EVER HAD A CHILD WITH ANOTHER MAN?.....

IF YES, WHEN _____

FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

VII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION

**AUTHORIZATION TO RELEASE PERSONAL INFORMATION
HIPAA Compliant**

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me to provide to New Life Agency, Inc. or to any agency authorized by New Life Agency, Inc. to collect any and all such information by means of U.S. Post , fax or e-mail.

I AUTHORIZE New Life Agency, Inc. to communicate with me or my representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, or additional coverages from New Life agency, Inc..

I UNDERSTAND the purpose of this Authorization is to allow New Life Agency, Inc. to determine eligibility and claim payment for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by New Life Agency, Inc. to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I UNDERSTAND that I may revoke this Authorization, except to the extent that New Life Agency, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to New Life Agency, Inc. Any such revocation may also have an impact upon my Underwriting or claims processing.

I UNDERSTAND that I can obtain a complete copy of New Life Agency, Inc. Privacy Policy either on New Life Agency, Inc. website or by contacting them directly and asking for a copy.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signed this day _____ of _____ 20 _____

Signature of proposed Program Participant (MALE)



NEW LIFE AGENCY

Insurance Agency

A New World of Insurance

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Complete:

1. To complete the application on line, tab to each area and type it in. To place checks in the boxes, you can either use the space bar or your mouse. Print, sign and date the application and fax it back with this completed cover sheet.

or

2. Print the application; complete each area by hand or typewriter. Print, sign and date it and fax it back with this completed cover sheet.

Submit:

1. Make sure all information below is completed then fax or mail both pages to New Life Agency, Inc.
41-750 Rancho Las Palmas Drive • Suite N-3 • Rancho Mirage, CA 92270
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TO:	Policy Coordinator	FAX: (877)952-5589
	E-Mail: sales@newlifeagency.com	PHONE: 877-952-5433 (LIFE)
		E-Mail: sales@newlifeagency.com

COMMENTS:

Thank you