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12295 Hwy 50, Suite 210, Bolton, Ontario L7E 1M2
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220 Dundas St. E., Unit 104, Belleville, Ontario K8N 1E2
tel | 613 962 7999 . fax | 613 967 1990

400 Bronte St. S., Unit 105, Milton, Ontario L9T 0H7
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ASTRA FERTILITY CLINIC

Prepare for First Visit /consultation at Astra

Welcome to Astra and thank you for trusting us with your fertility care.

It is our firm belief that most individuals are naturally born capable of reproducing without help! The truth is that your body naturally has all the tools to reproduce and is programmed to function independent of external input from no one and without doctor's help. The true art of fertility management is to identify the root cause of the underlying problem, provide appropriate and directed therapy targeting the underlying fertility problem. That will usually lead to fertility enhancement with subsequent restoration of your natural fertility or at least improve success rate of available assisted reproductive treatments (ART) like IUI and IVF.

We again stress on the fact that the most important step in your care and management is to identify the issues causing your difficulty conceiving accurately and clearly. In the absence of definitive diagnosis, non directed fertility treatment options are frequently and hastily offered on empiric basis, a practice style that can prove costly and very frustrating.

The diagnostic work up starts with accurate detailed history and information gathering. Please take the time to fill our history form accurately. It is also important to get any info related to previous imaging, testing, treatments, or surgeries.

Both partners are highly encouraged to attend for the first consult. Please arrive 10-15 min before your scheduled appointment**. Video conferencing will be our main tool to provide consultations during this COVID-19 Pandemic**. Most likely, you will have already been contacted by our receptionist who would have already reminded you of bringing or sending a photo of your health cards and sign an information release form to obtain needed information from previous health care providers.

Directions to the clinic are readily available on our website.

If you are **not able to attend your appointment please inform us at least 24 hours** before so we can utilize the allotted time for your appointment for another patient.

Fertility treatment cost:

Most of fertility investigations and treatments are OHIP and Fertility Program covered except for sperm wash, Private IVF procedures and Storage fees for sperms, eggs, or Embryos.

Surgical procedures at Astra are also covered except for fees to compensate for certain devices used for specific procedures not covered under OHIP.

Fertility drugs are also not covered by OHIP. You need to find out if your private benefits insurance plan covers Fertility medications.

Annual Block/Administrative Fees:

It is highly recommended that patients take advantage of the Annual Block/Administrative fee, which has shown to be highly regarded and appreciated by our clients. These fees allow us to continue providing exceptional quality services that our patients deserve and expect. These much-needed services are not covered by OHIP or Ontario Fertility Program.

Block Fees coverage goes way beyond your standard care during an active ongoing treatment cycle. Fertility care and support does not end with end of a treatment cycle or a procedure. Block fees provide you with on demand constant and timely access to continuous and ongoing expert care extending to management of early pregnancy complications or emerging gynaecological issues without delays awaiting a referral from your primary care physician. The annual fee also covers letters to employers or insurance companies, calling in prescriptions for maintenance medical issues not related to an active fertility treatment cycle.

Please keep in mind that opting out of block fees will by no means affect your access to services nor the quality of services related to your ongoing active treatment cycle (IUI or IVF). The purpose of the block fee is to offer you an access to discounted bundled and much needed additional services and care 7 days a week, all year round!

Please connect with admin staff for details regarding these uninsured fees as you may want to pay for those services as an annual block or pay individually as you go when services are provided.

We welcome you to Astra Fertility Group and wish you a pleasant and fruitful experience!

Infertility History Form

CONTACT INFORMATION

FEMALE:

First Name _____Middle Initial _____Last Name_____

Date of birth (MM/DD/YY) _____/_____/_____ Occupation _____

Health card number _____Version_____ Your age ☐

Home street address _____

City _____ State/Province_____Zip/Postal code _____

Indicate which number is best to call or leave messages:

□ home ( ) _____ □ cell ( ) _____

□ work ( ) _____ □ email _____

Are you married or have a partner? □ Yes (please complete partner section below) □ No
□ Divorced □ Other _____

SPOUSE/PARTNER:

First Name _____Middle Initial _____Last Name_____

Date of birth (MM/DD/YY) _____/_____/_____ Occupation _____

Health card number _____Version_____ Your age ☐

Home street address _____

City _____ State/Province_____Zip/Postal code _____

Indicate which number is best to call or leave messages:

□ home ( ) _____ □ cell ( ) _____

□ work ( ) _____ □ email _____

GENERAL INFORMATION:

Referring Doctor Name: _____ Phone number: _____

Reason for referral: _____

Do you have a drug plan that covers fertility medications: □ YES □ NO □ NOT SURE

GENERAL HISTORY:

How long have you been having regular unprotected intercourse? _____

How long have you been trying to actively get pregnant? _____

How long have you been trying to get pregnant with a Doctor's help? _____

Was the Doctor a: □ General Gynecologist □ Reproductive Endocrinology & Infertility Specialist

Approximately how many times a week do you have intercourse on average? _____

Does either you or your partner smoke? _____ How much (cig/day)? _____

Does either you or your partner drink alcohol? _____How much? _____

FEMALE HISTORY:

Height _____ Weight _____ Blood group _____

Skin color _____ Ethnic background _____

Do you have allergies? _____ If so, please list below and include allergies to medications if applicable:

_____

Menstrual periods occur every _____days. Are they regular? □ YES □ NO Duration of bleeding _____(days)

Amount of bleeding _____Are your periods painful? □ YES □ NO Age when started ____

Do you have endometriosis? □ YES □ NO Do you have any medical problems? □ YES □ NO If yes, explain:

_____ Do you take prescribed medications? □ YES □ NO If so please list names and dose below:

_____ Have you ever been diagnosed with pelvic inflammatory disease (PID)? □ YES □ NO

Have you had pelvic or abdominal surgeries and if so what were the findings? □ YES □ NO

_____

Number of pregnancies with current partner: _____ with previous partner (if applicable): _____

Number of miscarriages: _____abortions: _____tubal pregnancies: _____which tube? _____

Number of live births: _____ Vaginal birth:_____ Cesarean sections: _____

TREATMENT HISTORY

Have you had any of the following?

TEST/PROCEDURE	**YES or NO**	**RESULT**
Hysterosalpingogram OR sonohysteroscopy		
Laparoscopy		
Hysteroscopy		

Previos ART treatment	**YES or NO**	**How many cycles?**	**Any success?**
Clomiphene stimulation with intercourse			
Clomiphene stimulation with insemination			

Injectable FSHstimulation (Puregon/GonalF etc.) with intercourse			
Injectable FSHstimulation (Puregon/GonalF etc.) with insemination			
Insemination without any stimulation			
In vitro fertilization (IVF)			
In vitro fertilization with ICSI (IVF+ICSI)			

OTHER

What other information should we know about your case? _____

Any pertinent test results, procedures or problems identified? _____

Is there a family history of infertility? □ YES □ NO _____

Give details of IVF results, if applicable:

Stimulation protocol: _____ Number of follicles: _____

Number of eggs retrieved: _____ Number of embryos transferred: _____

Number of embryos frozen: _____ Outcome: _____

MALE HISTORY (if applicable):

Height _____ Weight _____ Blood group _____

Skin color _____ Ethnic background _____ Do you have allergies? _____ If so, please list below and include allergies to medications if applicable:

_____

Have you been previously married? □ YES □ NO Number of pregnancies with previous partner: _____

Do you have problems with erection or ejaculation? □ YES □ NO _____

Do you take prescribed medications? □ YES □ NO If so, please list names and dose below:

_____

Do you have any medical problems? □ YES □ NO If so, please explain:

_____

Have you had hormonal blood testing done? □ YES □ NO

Have you had previous surgeries? □ YES □ NO If so, please list:

_____

Is there a family history of infertility? □ YES □ NO _____

Have you had a semen analysis done: □ YES □ NO Date of test: _____

Result of test: _____ Where was test done: _____

Have you ever been diagnosed with azoospermia (no sperms)? □ YES □ NO

Have you ever had a testicular biopsy? □ YES □ NO When was it done: _____

Where was it done: _____ Result: _____

QUESTIONS:

Are there any specific questions you would like to address with the Doctor?

_____

_____

_____

_____

_____