

Miracle of the Month Questionnaire

Mom's Name: _____

Dad's Name: _____

Baby's Name: _____

Baby's DOB: _____ Weight: _____ Length: _____ Time of Birth: _____

1. How long did you struggle with infertility? _____

2. What was it like to go through infertility, both emotionally and psychologically? _____

3. How did you hear about the Center? _____

4. Describe your experience at the Center: _____

5. How has this experience changed your life? _____

6. Did you find the treatment difficult to go through? _____

Authorization to Release Medical Information

Date: _____

This will authorize the Center for Reproductive Health, Jamie M. Vasquez, M.D., Medical Director and/or the Center for Assisted Reproductive Technologies, to publish and or broadcast information and photographs, concerning the undersigned patient and her family, treated at the Center for Reproductive Health and/or the Center for Reproductive Technologies in Nashville, Tennessee. By my signature I am, therefore indicating my willingness to cooperate in the article and/or broadcast anticipated.

Please note this consent will remain in effect unless revoked by you in writing.

Patient Signature

Patient Signature

Patient Printed Name

Patient Printed Name