

*MARWAN M. SHAYKH, M.D.*  
*Assisted Fertility Program*

**Patient History Addendum**

I certify that all information given is true to the best of my knowledge. I agree to notify the doctor of any developments pertinent to my care. I understand that an accurate health history is vital to effective treatment.

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**Patient Name (Printed)**

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**Patient Signature**

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**Date**