We would like to welcome you to the Denali OB-GYN Clinic. We appreciate the opportunity to provide you the best women's health care in Alaska. We are committed to promoting your health through quality care, innovative education, advanced technology, and excellent patient service.

Enclosed you will find forms to be mailed back to us PRIOR to your scheduled appointment. Please complete the medical record release form and mail to the physician(s) who has provided you with any infertility or OB/GYN care. Do not return the release form to us. All other forms must be completely filled out (as well as you can) and mailed back to us at least three weeks before the appointment.

Please plan to arrive 15 minutes prior to our scheduled appointment time. Please bring your spouse/significant other to the appointment with you. Detailed cost information of various procedures or protocols can also be discussed.

Our clinic is located at 3976 University Lake Drive, Ste 300. The easiest way to access our office is off of Elmore Road. If you have any further questions, please feel free to call our clinic at (907) 222-9930.

Thank you for your confidence in our service and for giving us an opportunity to serve you. We look forward to seeing you at your appointment.

Sincerely,

The Providers & Staff at
Denali OB-GYN Clinic

Denali OB-GYN Clinic
3976 University Lake Drive, Ste 300 • Anchorage, Alaska 99508 Phone: 907.222.9930 • Fax: 907.222.9931

Medical History and Current Update

Today's Date ______________________

Name ____ DOB _________________________

OK to leave message/info at ______________________

Reason for today's visit ____

Other medical providers' ____

Date of last Pap smear? _______________ Date of abnormal paps in past ____________________________

Treatment ____

Last mammogram _______________ Results ____

Recent blood tests ____

Medications, Herbs, Supplements:

____

____

____

Birth Control Method:

Fill out on page 4-5 ______

Menstrual Information:

1st day of last period __________________

Days of total flow ____________________

Flow: ______light ______med. _____heavy

Are they regular? _________ Painful______

Cycle length (day 1 to day 1) ___________

Do you bleed between periods? __________

List Medication Allergies (describe reaction): None

____

Pregnancy Info: Fill on page 4

~~Total pregnancies: ______~~

~~Live Births: ___ Stillborn: ___~~

~~C-Sections: ___ Ectopic: ___~~

~~Miscarriage: ____ Abortion: ___~~

~~Living Children: ____~~

Family History:

____ Thyroid problems ____ High Blood Pressure

____ Bleeding problems ____ High Cholesterol

____ Alcoholism ____ Heart Disease ____ Osteoporosis

____ Diabetes ____ Depression ____ Stroke

Cancer (where) ______________________________

Prior Surgeries (hysterectomy, appendix, gallbladder, etc.) ____

____

Other Hospitalizations ____

Medical Problems (high blood pressure, thyroid, diabetes, etc.) _____________________________________

____

Social History: ____Married ____Single

Do you smoke: yes no Number of packs per day ____ for ____ years Quit (when) _______

Alcohol use: yes no Number of drinks per day ____ and/or drinks per week __________

Are you at risk for Hepatitis or AIDS? ________________

Do you have a history of, or are you currently using IV drugs? yes no

Review of Systems: Have you experienced any of the following in the last year?

___Depression ___Vomiting ___Vaginal discharge ___Hot flashes

___Problems with sleep ___Nausea ___Vaginal odor ___Cold intolerance

___Insomnia ___Abdominal pain ___Vaginal itching ___Weight change

___Heart palpitations ___Constipation ___Bleeding with intercourse ___Increased thirst

___Cough ___Diarrhea ___Painful intercourse ___Tremors

___Difficulty swallowing ___Bleeding with BMs ___Painful urination ___Appetite changes

___Chest pain ___Hemorrhoids ___Urinate frequently

___Shortness of breath ___Changes in hair/nails ___Urinate frequently every ____hours

___Breast lumps ___New moles ___Urinate during the night, how often ____

___Breast tenderness ___Changes in moles ___Stiffness/joint pain

___Nipple discharge ___Sores that won't heal

FEMALE PATIENT HISTORY

Please read all questions carefully and answer as thoroughly as possible

I. IDENTIFYING INFORMATION Date:_______________

Name: _______________________________________ Partner's Name:______________________________________

Address: ____

Home Phone: (________) ______- ___________________ Work Phone: (________) ______- ___________________

Answering Machine at home: Yes No OK to call at work: Yes No

Date of birth: ______________ Age: _____________ Partner's Date of birth: _____________ Age: ________

Duration of relationship: ________________________ Duration of infertility: ___________________________

Nature of present employment (title, brief description): ____

II. MEDICAL HISTORY

Weight _____________ Height _____________ Blood Type (if known) ___________________

Have you lost/gained greater than 20 pounds within the last year? Yes No

Do you follow a particular food diet or have any special dietary habits? Yes No

If yes, please specify ____

List the forms and frequency of regular, vigorous exercise (swimming, cycling, running)

Exercise _______________________________ Hrs/week: _______________________

Do you have or have you ever been diagnosed with or treated for (check all that apply):

__ Anemia
__ Epilepsy
__ Ovarian cysts
__ Appendicitis
__ Gallbladder problems
__ Parasitic infection
__ Gonorrhea
__ Pelvic infection
__ Blood transfusion
__ Heart disease Pneumonia
__ Breast milky discharge
__ Hepatitis
__ Poor sense of smell
__ Breast tenderness
__ Herpes

__ Rheumatic fever
__ Cancer – Specify:__________
____
__ Chlamydia
__ Chronic bronchitis
__ Chronic headaches
__ Colitis
__ Colorblind
__ Diabetes
__ Eating disorder
__ Hirsutism (excess hair growth)
__ High blood pressure
__ Immunization: German Measles (Rubella)
__ Kidney infection

__ Liver problems
__ Loss of balance
__ Measles: German
__ Measles: Regular
__ Scarlet fever
__ Seizures
__ Syphillis
__ Thyroid problems
__ Tuberculosis
__ Ulcers
__ Vaginitis (Trichomoniasis, yeast) # of episodes:__________
__ Visual disturbances

Have you ever had pelvic surgery? Yes No

If yes, please specify type and date: _____________________________

Type and date: _______________________________________

Have you ever received x-rays to the pelvic area for diagnosis or therapy? Yes No

If yes, please specify: __________________________________

Within the last year, have you taken any prescription medication? Yes No

If yes, list all prescriptions and problems for which you were taken them:

____

____

Are you taking any over-the-counter medications on a regular basis? Yes No

If yes, list all medications and the reason you are taking them:

____

____

Are you allergic to any medications? Yes No

If yes, please list meds and reactions: ______________________________

____

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

___ Alcohol – How many glasses per week do you usually drink? _______

Wine _________ Beer _________ Cocktails ____________

___ Cigarettes - Number of packs per day ______

___ Recreation drugs (marijuana, cocaine, etc.) past ____________ Current _____________

III. MENSTRUAL AND PREGNANCY HISTORY

Age at first period_____ Date of the first day of your last period _______________

Are you periods regular? (please circle) Yes No

If yes, what is the usual length (from day 1 of menses to day 1 of next menses)?________________

If no, how many times per year do you menstruate? ___________________

Provera or progesterone needed to initiate bleeding? Yes No

What is the usual duration of your period?_____________ Use: Tampons ________ Pads _________

Are cramps present before, during, or after your period? Yes No

Are cramps: ____ mild ___moderate ___ severe

Do you spot of bleed between periods? Yes No

How many times have you been pregnant (Including elective termination)? ___________________

Pregnancy	Year Conceived	How Long to Conceive	Infertility Therapy to Conceive	Miscarriage? Ectopic? Stillborn? Elective Termination?	Date Baby Born	Vaginal Delivery or C-Section?	Boy or Girl?	Is current partner the Father?
1st								
2nd								
3rd								
4th								
5th								

What drugs have you taken for infertility? Check all that apply: ________None _________ Antibiotics

__ Clomiphene citrate (Clomid, Serephene)

__ hMG (pergonal)

__ hCG (profasi, A.P.L.)

__ prednisone (or cortisone-like drugs)

__ danazol (Danocrine)

__ GnRH or LHRH (Factrel)

__ bromocriptine (parlodel)

__ Depo-Lupron-

__ estrogens

__ urofllitropin or FSH (Metro din)

__ progesterone

__ other – specify: ____________

IV. CONTRACEPTIVE/SEXUAL HISTORY

What forms of contraception have you used in the past? (check all that apply)

__ Pills Name: ______________________________________

__ IUD Name: ______________________________________

__ Diaphragm

__ Withdrawal

__ Foams/Jellies condoms

__ Rhythm

__ None

__ Other – specify: ____________________

For each contraceptive method used, specify length of use, and reason for discontinuation:

Method	Year and length of use	Reason for discontinuation
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

If you have ever been on birth control pills, were your periods regular after stopping them? Yes No

How many times per week do you and your partner have intercourse? _________

How many times do you have intercourse around ovulation? _________

Is intercourse painful or difficult for you? __________

Do you use lubricants for intercourse? ____________

If yes, which one ______________________

Do you douche after intercourse? Yes No

V. HISTORY OF INFERTILITY

Have you been treated for infertility before: Yes No

If yes, who was you physician? ____

What cause of infertility was diagnosed? ________________________________

Which of the following tests have you had performed? Check all that apply and list results, if known:

Test	When?	Results
__ BBT	When?:_______________	Results:______________________
__ Post coital test	When?:_______________	Results:______________________
__ Hormonal assays (FSH, LH, prolactin, estrogen, DHEA-S, testosterone, progesterone)	When?:_______________	Results:______________________
__ Endometrial biopsy	When?:_______________	Results:______________________
__ Hysterosalpingogram	When?:_______________	Results:______________________
__ Antibodies	When?:_______________	Results:______________________
__ Laparoscopy, Hysteroscopy	When?:_______________	Results:______________________
__ Mycoplasma, Chlamydia cultures	When?:_______________	Results:______________________
__ Thyroid tests	When?:_______________	Results:______________________
__ Rubella immunity	When?:_______________	Results:______________________
__ Pap smear	When?:_______________	Results:______________________
__ Other – specify:____________________________	When?:_______________	Results:______________________

Have you ever had a tubal ligation? Yes No

If yes, specify date: ____________________

Have you ever had surgery for a tubal reversal? Yes No

If yes, specify date: ____________________

Have you ever had surgery for lysis of adhesions? Yes No

Have you ever had a cervical conization, cautery, or cryosurgery? Yes No

Have you ever-had any other surgery (D&C, ovarian, appendectomy, thyroid)? Yes No

If yes, specify type and date: ______________________________

Have you ever undergone artificial insemination or in vitro fertilization? Yes No

If yes, using partner or donor sperm? ___________________________________

Is your partner seeing a doctor for evaluation of infertility? Yes No

If yes, state physician name and location: _______________________

Does the doctor feel that your partner has an infertility problem? Yes No

If yes, what is the diagnosis and how is he being treated? ____________

Has he ever fathered a child with another partner? Yes No

If yes, when? ________________________________

Have you ever undergone ovulation induction therapy?

If yes, how many cycles? ______ Clomid ______ Pergonal/Metrodin

______ Combination of Clomid/Pergonal/Metrodin

If yes, specify the average number of mature follicles (> or = 16 mm) noted with ultrasound therapy

____

____

Were there any complications during or after your pregnancies? Yes No

If yes, please explain ______________________________________

How long have you been trying to get pregnant? ______________

Did your mother have any difficulty with conception or pregnancy? Yes No

If yes, please explain ______________________________

Did your mother take DES (diethylstilbestrol) while she was pregnant with you? Yes No

VI. FAMILY HISTORY

Is there a family history of infertility? Yes No

If yes, please list ail members and relationship to you:

____

____

____

Is there a history of hormonal disorders in your family? Yes No

If yes, who and what type: ____

MALE PATIENT HISTORY

Please read all questions carefully and answer as thoroughly as possible

I. IDENTIFYING INFORMATION Date:________________

Name: ____ Partner's Name:____

Address: ____

Home Phone: (________) ______- ____________________ Work Phone: (________) ______- ____________________

Answering Machine at home: Yes No OK to call at work: Yes No

Date of birth: ________________ Age: _______________ Partner's Date of birth: _______________ Age: _________

Duration of relationship: ___________________________ Duration of infertility: ______________________________

II. TRAVEL/WORK AND GENERAL BACKGROUND

Nature of present employment (title, brief description): ____

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

__ Heat __ Toxic Fumes __ Chemicals __ Nuclear Radiation

__ Other, Please specify ____

III. MEDICAL HISTORY

Weight _______ Height _______ Blood Type (if known) ______________

Have you lost/gained greater than 20 pounds within the last year? Yes No

Do you follow a particular food diet or-have any special dietary habits? Yes No

If yes, please specify ____

Do you frequently take saunas, steam baths or whirlpool? Yes No

Have' you ever had surgery in the pelvic area? Yes No

If yes, specify date and type ____

Have you ever received X-rays in the pelvic area for therapy or diagnosis? Yes No

If yes, explain: ____

List the forms and frequency of regular, vigorous exercise (swimming, cycling, running)

Exercise ___________________________ Hrs/week __________________________

Do you have of have you ever been diagnosed with or treated for (check all that apply):

__ Anemia	__ High blood pressure	__ Mumps
__ Appendicitis	__ Kidney infection	__ Testes Tumor
__ Arthritis	__ Liver problems	__ Thyroid problems
__ Blood transfusion	__ Loss of balance	__ Tuberculosis
__ Breast milky discharge	__ Parasitic infection	__ Colitis Ulcers
__ Breast tenderness	__ Pneumonia	__ Colorblind
__ Cancer - Specify	__ Prostatitis	__ Diabetes
__ Chlamydia	__ Rheumatic fever	__ Dizziness
__ Chronic bronchitis	__ Scarlet fever	__ Mumps w/testes involved
__ Epilepsy	__ Seizures	__ Neurological problems
__ Gallbladder problems	__ Syphillis	__ Nogonococcal
__ Gonorrhea	__ Testes Infection	__ Urethritis
__ Heart disease	__ Testes Injury	__ Visual disturbances
__ Hepatitis	__ Chronic headaches	
__ Herpes	__ Measles (German/Regular)	

Have you ever been treated for cancer? Yes No

If yes, explain therapy: ____

Within the last year, have you taken any prescription medication? Yes No

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? Yes No

If yes, list all medications and diagnoses:

____

Have you had a high fever (over 102 F) during the past 3-4 months? Yes No

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

___ Alcohol – How many glasses per week do you usually drink? _______

Wine _________ Beer _________ Cocktails ____________

___ Cigarettes - Number of packs per day ______

___ Recreation drugs (marijuana, cocaine, etc.) past ____________ Current _____________

IV. SEXUAL HISTORY

Are you circumcised? Yes No

When you were a child, were both testes descended into the scrotum? Yes No

At what age did you begin shaving regularly or start to grow a beard?___________

How many times have you been married? _____________

Have you produced a child with another partner? Yes No

If yes, how long did it take to produce the child? ______________

When was-this (dates)? ____________________________________

Have you ever tried to produce a child with another partner? Yes No

Do you have trouble getting an erection? Yes No

Do you have trouble maintaining an erection? Yes No

Do you have trouble with ejaculations? Yes No

If yes, ________Premature ejaculations ________Retrograde ejaculations

Do you feel that some of your ejaculate is deposited in the vagina? Yes No

Do you ever have orgasms without ejaculation during masturbation? Yes No

Do you have any abnormal discharge from the penis? Yes No

How many times per week do you and your partner now have intercourse? ______

How many times do you have intercourse around ovulation? ___________

Have you noticed a change in your sexual drive recently? Yes No

Have you had an injury or abnormality of penis, testicles, or prostate? Yes No

If yes, when?________________________ Outcome/Result ____________________________

V. FAMILY HISTORY

Have you been treated for infertility before? Yes No

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 (Serophene, Clomid)
___ Tamoxifen
___ Testolactone
___ Bromocriptine (parlodel)
___ Testosterone or Male Honnone
___ hMG (parlodel)
___ hCG (profasi, APL)
___ Fluoxymesterone (Halotestin)
___ GnRH or LHRH (Factrel)
___ Urofollitropin or FSH (Metro din)
___ Other – specify ___________
___ None

Have you ever had a varicocele repair? Yes No

If yes, when? ______________________________

Have you ever had a vasectomy reversal or repair? Yes No

If yes, when? ______________________________

Have you and your partner ever tried artificial insemination? Yes No

If yes, using ___your sperm? ___donor sperm?

Have you 'and your partner ever tried in vitro fertilization? Yes No

If yes, when and where? ___________________________________

Which' of the following tests have you had performed? Check all that apply and list results, if known:

___ Semen Analysis When?:______________ Results:____________________________
___ Hormonal assays (FSH, LH, prolactin, testosterone) When?:______________ Results:____________________________
___ Chromosome Test When?:______________ Results:____________________________
___ Hamster Egg Test When?:______________ Results:____________________________
___ Antibodies When?:______________ Results:____________________________
___ Chlamydia Test When?:______________ Results:____________________________
___ Mycoplasma test When?:______________ Results:____________________________
___ Thyroid tests When?:______________ Results:____________________________
___ Testicular biopsy When?:______________ Results:____________________________
___ X-ray or ultrasound of testes When?:______________ Results:____________________________
___ Other – specify_________________________ When?:______________ Results:____________________________

Is your partner currently seeing a doctor for evaluation of infertility? Yes No

If yes, specify physician name and location _________________________

Does the doctor feel that your partner has an infertility problem? Yes No

If yes, what is the diagnosis and how is she being treated? ____

Has your partner ever conceived a child with someone other than yourself? Yes No

DATE ______________________

PATIENT REGISTRATION

1. PATIENT INFORMATION

SOCIAL SECURITY # ______________________

FIRST NAME ______________________ MIDDLE _____

LAST NAME ______________________

SEX ☐M OR ☐F DATE OF BIRTH ______________________

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐OTHER

CHECK ONE: ☐EMPLOYED ☐RETIRED ☐FULL TIME STUDENT

EMPLOYER ______________________

RACE/ETHNICITY ______________________

MAILING ADDRESS ______________________

____

CITY ______________ STATE ______ ZIP __________

I (**may**) or (**may not**) have medical information and test results left on my voicemail at ______________________

HOME PHONE (_____) ______________________

CELL PHONE (_____) ______________________

WORK PHONE (_____) ______________________

REFERRING PHYSICIAN ______________________

EMAIL ______________________

2. INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

INSURANCE COMPANY ______________________

SUBSCRIBER NAME ______________________ DATE OF BIRTH ______________

SOCIAL SECURITY # ______________________ SUBSCRIBER RELATIONSHIP ______________

_POLICY # ______________ GROUP # ______________ PHONE (______) ______________

3. SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________

SUBSCRIBER NAME ______________________ DATE OF BIRTH ______________

SOCIAL SECURITY # ______________________ SUBSCRIBER RELATIONSHIP ______________

_______POLICY # ______________ GROUP # ______________ PHONE (______) ______________

4. EMERGENCY CONTACT

FIRST NAME ______________________ MIDDLE _____

LAST NAME ______________PHONE______________

FIRST NAME ______________________ MIDDLE _____

LAST NAME ______________PHONE______________

5. SPOUSE / PARENT

SOCIAL SECURITY # ______________________

RELATIONSHIP ______________________

FIRST NAME ______________________

LAST NAME ______________________

ADDRESS ______________________

____

CITY ______________ STATE ______ ZIP __________

SEX __________ DATE OF BIRTH ______________

DAY PHONE (_______) ______________________

EMPLOYER ______________________

6. OTHER INFORMATION

LIST NAMES OF UP TO TWO PEOPLE WITH WHOM THE DOCTOR MAY DISCUSS YOUR HEALTH INFORMATION

1. ______________________

2. ______________________

I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care. I authorize direct payment to the provider/s for my medical and/or surgical care. I understand that I am responsible to pay any non-covered services. I understand that if I am uninsured, I am responsible to pay for any services provided. I have read and agree to the Patient Financial Policy.

______________________ SIGNATURE

__________ DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, __________________________, acknowledge and agree that I have been offered a copy of Denali OB-GYN Clinic's Notice of Privacy Practices.

____ ___________________

Patient Signature Date

____ ___________________

Patient Legal Representative (If applicable) Date

____ ___________________

Print Name of Legal Representative Date

FOR CLINIC USE ONLY:

Denali OB-GYN group made the following good efforts to obtain the above referenced individuals written acknowledgement of receipt of the Notice of Privacy Practice:

(*Identify the efforts that were made to obtain the individual's written acknowledgement, including why (if known) the written acknowledgement was not obtained.*)