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

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? ________________________________

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

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? ______

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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:

Test	When?	Results
☐ 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.*)