3976 University Lake Dr. Ste 300, Anchorage, AK 99508 · Phone (907)222-9930 · Fax (907)222-9931

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 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:_____ Date of Birth:_____

Ok to Leave Message/Info at:_____

Reason for today's visit:_____

Other Medical Provider's:_____

Date of Last Pap Smear:_____ Date of Abnormal Paps in the Past:_____

Treatment:_____

Last Mammogram:_____ Results:_____

Recent Blood Tests:_____

Family History

☐ Thyroid Problems ☐ High Blood Pressure

☐ Bleeding Problems ☐ High Cholesterol

☐ Alcoholism ☐ Heart Disease ☐ Osteoporosis

☐ Diabetes ☐ Depression ☐ Stroke

☐ Cancer (where)_____

OB-GYN Clinic

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:_____

OB-GYN Clinic

Do you have or 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 prescription 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 diagnosis:

_____

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

Do you use or have you used (check all that apply): Yes ☐ No ☐

☐ Alcohol How many glasses per week do you usually drink?

☐ Wine_____ ☐ Beer_____ ☐ Cocktails_____

☐ Cigarettes Number of packs per day_____

☐ Recreational 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. HISTORY OF INFERTILITY

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 Test	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

OB-GYN Clinic

FEMALE PATIENT HISTORY

I. 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
- ☐ Appendicitis
- ☐ Blood Transfusion
- ☐ Breast Milky Discharge
- ☐ Breast Tenderness
- ☐ Cancer – Specify:_____
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Gallbladder Problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ Immunization: German Measles (Rubella)
- ☐ High Blood Pressure
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ Parasitic Infection
- ☐ Pneumonia
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Syphillis
- ☐ Poor Sense of Smell
- ☐ Eating Disorder
- ☐ Hirsutism (excess hair growth)
- ☐ Measles (German/Regular)
- ☐ Ovarian Cysts
- ☐ Pelvic Infection
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Colitis Ulcers
- ☐ Colorblind
- ☐ Diabetes
- ☐ Dizziness
- ☐ Mumps w/Testes Involved
- ☐ Neurological Problems
- ☐ Visual Disturbances
- ☐ Vaginitis (Trichomoniasis, Yeast)
  # of episodes:_____

Have you ever had pelvic surgery? Yes ☐ No ☐
If yes, please specify 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 prescription 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 diagnosis:

_____

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list meds and reaction:_____

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

☐ Alcohol How many glasses per week do you usually drink?

☐ Wine_____ ☐ Beer_____ ☐ Cocktails_____

☐ Cigarettes Number of packs per day_____

☐ Recreational Drugs (marijuana, cocaine, etc.) Past_____ Current_____

II. MENSTRUAL AND PREGNANCY HISTORY

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

Are your periods regular? Yes ☐ No ☐

If yes, what is the usual length (from day 1 of period to day 1 of next period) _____

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 or 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) ☐ Danazol (Danocrine)

☐ hMG (pergonal) ☐ GnRH or LHRH (Factrel) ☐ Progesterone

☐ hCG (profasi, APL) ☐ Bromocriptine (parlodel) ☐ Estrogens

☐ Prednisone (or cortisone-like drugs) ☐ Depo-Lupron ☐ Other – Specify_____

III. CONTRACEPTIVE / SEXUAL HISTORY

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

☐ Pills Name:_____ ☐ Foams / Jellies Condoms
☐ IUD Name:_____ ☐ Rhythm
☐ Diaphragm ☐ None
☐ Withdrawal ☐ Other – Specify_____

For each contraceptive method used, specify the 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? Yes ☐ No ☐

Do you use lubricants for intercourse? Yes ☐ No ☐
If yes, which one _____

Do you douche after intercourse? Yes ☐ No ☐

IV. HISTORY OF INFERTILITY

Have you been treated for infertility before: Yes ☐ No ☐
If yes, who was your 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:

☐ 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 ☐ 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? Yes ☐ No ☐
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 ☐

V. FAMILY HISTORY

Is there a family history of infertility Yes ☐ No ☐
If yes, please list all members and relationship to you: _____
_____

Is there a history of hormonal disorders in your family? Yes ☐ No ☐
If yes, who and what type _____

Patient Financial Responsibility for Infertility Treatment

Infertility services have varying benefits with insurers. Though Denali OB-GYN will attempt to verify if these services are a covered benefit with your plan, we highly recommend you also contact your insurance to clearly understand what is and is not considered a covered benefit. Ensure you understand any restrictions your insurance company may impose such as referrals, prior authorization, network provider restrictions, etc.

Below we have supplied some codes used by us and insurers to communicate your service. This may be helpful when speaking with your insurance Customer Service Representative. Our Patient Representative is available to assist you with questions prior to, during and after your services are rendered.

Payment in full is due up front **prior** to services being rendered. We do not offer discounts or payment plans for this service. We will, however, file your insurance as a courtesy, patient responsibility amounts include but not limited to non-covered services, non-allowed, deductibles, coinsurance and, co-payments. **Weekend scheduled procedures must be paid-in-full prior to 12:00pm on Friday.**

I, _____agree to pay for services considered not a benefit of my insurance prior to such care being rendered. I also understand that I am responsible to pay my cost share including but not limited to deductible, coinsurance, and copay as deemed due by my insurance company. I agree to keep my account current and in good standing throughout the course of my care.

Costs listed below are quoted for services rendered at Denali OB-GYN.

Infertility treatment services include but are not limited to:

Service	*CPT Code*	*Diagnosis code*	*Standard Fee*
Insemination	58322	Z31.89	$708.00
Sperm Washing	58323	Z31.89	$119.00
New Patient Office Visit	99202-99205	Z31.69, Z31.49	$233.00 - $732.00
Est Patient Office Visit	99212-99215	Z31.69, Z31.49	$182.00 - $599.00

Infertility **diagnostic** services may include but are not limited to:

Service	*CPT Code*	*Diagnosis code*	*Standard Fee*
Follicle US	76857	Z31.41	$278.00
Trans Vaginal US	76830	Z31.41	$640.00
Sonohysterogram	58340	Z31.41, Z31.49	$1,722.00
Sonohysterogram RS&I	76831	Z31.41, Z31.49	$628.00

Signature: _____ **Date: _____**