Directions to Denver Fertility/Albrecht Women’s Care
9780 Pyramid Court, Ste. 260
Englewood, CO 80112
720-420-1570

We are located on the northeast corner of I-25 and Lincoln Avenue.

✓ From I-25, go east on Lincoln Ave.
✓ Turn left (north) on Havana St. and stay in the left lane.
✓ Turn left at the light - Meridian Blvd (you will veer west).
✓ Turn left on Pyramid Ct.
✓ We are the first building on the left.
✓ Suite 260
PATIENT INFORMATION

Name: ____________________________ DOB: ____________________________

Address: ____________________________________________________________
Street / Apt # ____________________________ City ____________________________
State ____________________________ Zip ____________________________

Primary Phone: ____________________________ Alternate Phone: ____________________________

Employer: ____________________________ Occupation: ____________________________

Email: ____________________________

Sex: □ Female □ Male Marital Status: □ Married □ Single □ Divorced □ Widowed

Primary Care Physician: ____________________________ OB/GYN Physician: ____________________________

How did you hear about our office? □ Referring Physician: ____________________________ □ Patient/Friend: ____________________________
□ Other: ____________________________ □ Our Website □ Online Review □ Google □ Social Media
□ Online Ad □ TV □ 5280 Magazine □ Women's Edition Magazine

PHARMACY

Name: ____________________________ Phone (REQUIRED): ____________________________

Address: ____________________________

SPOUSE/PARTNER INFORMATION or EMERGENCY CONTACT

Name: ____________________________ DOB: ____________________________

Primary Phone: ____________________________ Relationship: ____________________________

INSURANCE

Primary Insurance: ____________________________ Secondary Insurance: ____________________________

Claims Address: ____________________________ Claims Address: ____________________________

Phone Number: ____________________________ Phone Number: ____________________________

ID Number: ____________________________ ID Number: ____________________________

Group Number: ____________________________ Group Number: ____________________________

Effective Date: ____________________________ Effective Date: ____________________________

Policy Holder Name: ____________________________ Policy Holder Name: ____________________________
DOB: ____________________________ DOB: ____________________________
SSN: ____________________________ SSN: ____________________________

The above information I have given is true and correct. I understand that I am ultimately responsible for payment of all services. If billing my insurance, I authorize payment of medical benefits to undersigned Denver Fertility/Albrecht Women's Care for their services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims.

Patient Signature ____________________________ Date ____________________________
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means; for example, sending correspondence to the individual’s email instead of the individual’s home address.

I give Denver Fertility/Albrecht Women’s Care permission to contact me by the following means;

CHECK ALL THAT APPLY

■ Telephone: ________________________________
  □ OK to leave a message with detailed information
  □ OK to leave a message with other family members
  □ OK to discuss my health information with spouse or partner; Name: ________________________________
  □ Do not leave a message

■ Email: ________________________________
  □ OK to contact me via email and/or email me with detailed information
  □ Do not contact me by email

■ Written Communication
  □ OK to send mail to my home address
  □ OK to send mail to my work/office address
  □ OK to fax to this number: ________________________________

■ Other: ________________________________

IF YOU ARE A MINOR:

□ OK to release information to parent or guardian; Name: ________________________________
□ Do not release information to anyone other than myself

NOTE: Uses and disclosures may be permitted without prior consent in case of an emergency.

Print Patient Name ________________________________ Date of Birth ________________________________

Patient Signature ________________________________ Date ________________________________
Notice and Acknowledgement of Privacy Practices

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that Denver Fertility/Albrecht Women’s Care and all staff members continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”. We are required by law to maintain the confidentiality of health information that identifies you. The Department of Health and Human Services has established a “Privacy Rule” to help insure that your personal information is protected from unnecessary distribution. The Privacy rule has also been created in order to provide a standard for certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient to carry out treatment, payment, or other health care operations. We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. As our patient, we want you to know that we respect the privacy of your personal medical records, and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. None of your private information will be released to anyone without your expressed written consent. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent an inappropriate use of PHI. We also want you to know that we support your full access to your personal medical records. Other businesses that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations, or payment. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information. Should you refuse to disclose your personal health information to us, we have the right to refuse to treat you under the law. Should you disclose your information to us, but refuse it to your insurance company, you will be responsible for the full balance on your account at the time of service.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE PERSONAL HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice including, but not limited to; our doctors, nurses, medical assistants, laboratory personnel, or indirectly with any provider we refer you to, may use or disclose your PHI in order to treat you. Additionally, we may need to disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and for what range of benefits. We may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for costs; such as families or insurance companies. Also, we may use your PHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations; our practice may use your PHI to evaluate the quality of care you receive from us or to contact cost-management and business planning activities for our practice.

4. **Appointment Reminders/Emails.** Our practice may use and disclose your PHI to contact you or a family member who answers the phone (or to leave a voicemail) to remind you of an upcoming appointment. We may also send you emails that others may have access to.

5. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child’s medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OR YOUR PHI IN CERTAIN CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purposes of:
2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose you PHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. **Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

6. **Organs and Tissue Donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **Military.** Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. **Workers’ Compensation.** Our practice may release your PHI for workers’ compensation and similar programs.

I acknowledge that I have read this Notice of Privacy Practices; which describes ways in which Denver Fertility/Albrecht Women’s Care may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. I understand that this information may be disclosed electronically by Denver Fertility/Albrecht Women’s Care. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in this document.

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Print Patient Name ____________________________

Date of Birth ____________________________

Patient Signature ____________________________

Date ____________________________

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FINANCIAL POLICY

Thank you for choosing Denver Fertility/Albrecht Women's Care. We are committed to providing you with quality and affordable healthcare. The following information is provided to help you understand our financial policies.

Required Information. Prior to any services being provided, we must obtain a current insurance card, a photo ID, and a completed patient information packet. If you do not have insurance or an up-to-date and correct insurance card, you will be responsible for payment at the time of service.

Insurance Benefits. We participate with most insurance plans. We recommend that you check with your insurance company to determine what your insurance benefits are prior to your first appointment; as knowing your benefits is your responsibility. If we do not participate with your insurance, payment in full is due at the time of service.

Co-Payments and Deductibles. All co-pays and deductibles must be paid at the time of service and are a part of your contract with your insurance company.

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. If this is the case, you must pay at the time of service.

Claims Submission. We will submit claims on your behalf to your insurance company. Occasionally, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. If you do not wish to have your services submitted to your insurance, you can opt for the self-pay discount. This discount is ONLY available when paid at the time of service. If you choose this option, we will not be able to bill your insurance company at a future date.

Insurance Coverage Changes. If your insurance changes, it is your responsibility to notify us of any changes.

Self-Pay Discount. If you do not have insurance or your insurance will not cover services, we offer a self-pay discount. This discount will ONLY be given if paid at the time of service.

Credit Card Policy. At the time of your first visit, you will be asked for a credit card number to be placed on file in your electronic medical record (EMR). This information will be held securely in your EMR. After the insurance company has paid their portion of the charges and notified us of the remaining balance owed by you, your credit card will be charged. A copy of the charge and a receipt will be sent to you for your records. This policy in no way will compromise your ability to dispute a charge or question your insurance company’s determination of payment. We will charge you the portion that your insurance company has determined is your responsibility. If the balance is large, the billing office will contact you prior to charging your credit card. Co-pays are still due at the time of service and must be paid at that time.

Non-Payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing office. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Patients will be responsible for the cost of collection efforts such as; referring the account to a collection agency or attorney fees. If your account remains unpaid, you and your immediate family members may be discharged from the practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will only be able to treat you for emergency problems.

Missed Appointments. Our policy is to charge for missed appointments that are not canceled within a reasonable amount of time. These charges will be your responsibility and will be billed directly to you, not your insurance company.

I acknowledge that I have read and understand the above information regarding the financial policies of Denver Fertility/Albrecht Women's Care.

Printed Patient Name ______________________  Signature ______________________  Date ________________
OPTIMIZING YOUR CHANCES FOR A HEALTHY PREGNANCY

As you initiate your treatment at Denver Fertility, we would like to take this time to remind and inform you (and your partner) of the importance of updated health maintenance; including, when appropriate, physical examinations, pap smears and breast screening with your primary care provider(s). Because the providers at Denver Fertility are subspecialists and do not provide health care outside of the area of reproductive medicine, we ask that you update any of the above examinations and/or diagnostic testing with your primary care provider and/or obstetrician/gynecologist; please note, we often request copies of these documents. We also recommend and sometimes require that you be seen by appropriate sub-specialist(s) (e.g. cardiology, rheumatology, neurology, psychiatry, maternal-fetal medicine) who are currently or may need to be involved in your care to inform them that you are undergoing infertility treatment to pursue pregnancy and discuss any relevant adjustments to your treatment plan. You should also review the safety and management of any current medications you are taking with the prescribing provider and establish a healthcare plan during pregnancy to optimize your chances of a healthy and an uncomplicated pregnancy. If you have questions about the safety of your medications, please seek consultation with a maternal-fetal-medicine specialist. We will do our best to assist you, but we want you to be aware that neither your nursing team nor the Denver Fertility providers can be responsible for reminding you to update your health care needs or send the above records to Denver Fertility.

During the course of your treatment, Denver Fertility may recommend and/or require appropriate documentation of certain pre-conceptual laboratory tests, such as a complete blood count (CBC), chemistry levels, rubella immunity, varicella immunity, thyroid evaluation (TSH and free T4), vitamin D level and infectious disease testing. When appropriate, your BSF providers recommend that you be vaccinated in collaboration with your primary care provider. Please note that many vaccines are "live-attenuated" (e.g. MMR and varicella) vaccines and pregnancy is contraindicated for 30 days after vaccination. Please check with your prescribing provider regarding safety and pregnancy precautions prior to vaccination. Additional information about vaccinations as well as their safety during pregnancy may be found at the following CDC website: https://www.cdc.gov/vaccines/pregnancy/pregnant-women. Pregnant women have a higher risk of serious complications from influenza than non-pregnant women. Thus, we recommend the influenza vaccination prior to, during, or after pregnancy. In some instances, you may need thyroid and/or vitamin D supplementation and your Denver Fertility provider may elect to prescribe thyroid and/or vitamin D supplementation while under our care; however, you will need to follow-up with your primary care provider for long-term care and management of these issues.

ZIKA

Zika is a virus, spread primarily through mosquito bites, which may cause fever, rash, joint pain, and red eyes. Zika may also be spread by sexual intercourse, from a pregnant mother to her unborn baby, and through donated blood or organs. If you have Zika while you are pregnant, it can cause serious and often severe problems and birth defects for your baby. Currently, the Zika virus has been found in Florida and Texas, as well as the United States territories of Puerto Rico, the Virgin Islands, and American Samoa. Most cases have been in Central and South America, Mexico, the Caribbean, and the Pacific Islands. For the most current information about the Zika outbreak, including the latest list of places where mosquitoes carry Zika, please consult the CDC (www.cdc.gov) and/or WHO (www.who.int) websites.

The best way to prevent Zika virus infection is to avoid the mosquitoes that carry it and thus, we recommend that you avoid travel to areas where the Zika virus has been identified. If you must travel to areas where Zika is present, we recommend the following precautions:
• Stay inside when the mosquitoes are most active - they bite mostly during the daytime and at twilight (the very early morning, and the few hours before sunset). Buildings with screens and air conditioning are safest;
• Wear shoes, long-sleeved shirts, long pants, and a hat when you go outside;
• Wear bug spray or cream that contains DEET or a chemical called "picaridin." Check the label to make sure. Do not use DEET on babies younger than 2 months;
• On your clothes and gear, use repellents that have a chemical called "permethrin.";
• Drain any standing water if possible, such as wading pools, buckets, and potted plants with saucers - mosquitoes breed in standing water.

Some experts suggest the following guidelines, which are especially important for people who could get pregnant (and their partners). These guidelines are for people who do not live in areas with Zika virus:

• Men who might have been exposed to Zika should use condoms, or not have sex, for at least 6 months. The 6 months should begin after symptoms start (if the man has symptoms) or after the last possible exposure (if he doesn’t).
• Women who might have been exposed to Zika should use condoms, or not have sex, for at least 8 weeks. The 8 weeks should begin after symptoms start (if the woman has symptoms) or after the last possible exposure (if she doesn’t).
• Men and women who might have been exposed to Zika and whose partner is pregnant should use condoms, or not have sex, for the rest of the partner’s pregnancy. This is especially important, even if the person does not have symptoms.

If you think you may have been exposed to Zika please let us know as soon as possible as testing for the virus may be warranted prior to pregnancy.

By my signature, I/we acknowledge, after appropriate opportunity for questions, understand the above information and/or recommendations. I/we acknowledge the importance of addressing relevant health issues, including current medications with the appropriate primary-care provider (or other prescribing provider) or maternal-fetal medicine specialist prior to pregnancy in an effort to maximize the chances of a healthy and uncomplicated pregnancy. I/we understand that non-compliance regarding the above issues may adversely impact potential treatment(s), pregnancy(ies) and the health of my/our future children.

Print Patient Name ___________________________  Patient Signature ___________________________  Date ____________

Print Witness Name ___________________________  Witness Signature ___________________________  Date ____________
REQUEST FOR RELEASE OF MEDICAL RECORDS

Last Name ___________________________ First Name ___________________________ M.I. ___________________________ DOB ___________________________

Street Address ___________________________ City ___________________________ State ___________________________ Zip Code ___________________________

Phone ___________________________ Other Name(s) - if applicable ___________________________

RECORDS TO BE RELEASED FROM:

Practice/Physician Name ___________________________

Street Address ___________________________ City ___________________________ State ___________________________ Zip Code ___________________________

Phone ___________________________ Fax ___________________________

RECORDS TO BE SENT TO:
Denver Fertility / Albrecht Women’s Care
9780 Pyramid Court, Suite 260
Englewood, CO 80112
Fax: 866-657-9471 or Email: info@albrechtwomenscare.com
Phone: 720-420-1570

Records of care from (dates): ___________________________ to ___________________________

____ Complete Medical Record __________ Laboratory Reports __________ Medical Imaging Reports

____ Pathology Reports __________ Surgical Records

____ Other (specify): ___________________________

I understand by signing this release form, I give my permission to release my confidential information to the above named physician/clinic. My signature also authorizes the release of any information relating to AIDS or HIV testing, alcohol use, or mental status contained in my records. I understand I can revoke this request at any time in writing, except to the extent that action has already been taken.

Signature: ___________________________ Date: ___________________________

Witness: ___________________________ Date: ___________________________

Appointment Date and Time: ___________________________
FEMALE MEDICAL AND FERTILITY HISTORY

Date of Appointment: __________ Last Name: ___________ First Name: ___________ DOB: ___________
Age: __ Martial Status: M ☐ S ☐ Partner's Name: ______________________ Age: __
How did you hear about our office? ___________________________________________

What is the reason for your appointment today? ____________________________

What was the first day of your last menstrual flow? __________ Your age of your first menstrual flow: ___________

What is the length of your menstrual cycle? (Days between the first day of one period to the next): ________________

How many days does the flow last? ______ How many are heavy? __________

Do you have spotting or bleeding between periods? Yes ☐ No ☐

What is the number of pads or tampons used in 24 hours on heavy days? Pads ___ Tampons ___

Do you use tampons and pads together? Yes ☐ No ☐

Do you soak through? Yes ☐ No ☐ If so how often? __________

Do you have menstrual cramps? Yes ☐ No ☐

If yes, are they? Mild ☐ Moderate ☐ Severe ☐ How many days? _____

Do you use any medications for menstrual cramps? Yes ☐ No ☐ If yes, please list the medications below: ________________________________

Do you take any prescription medications? If yes list the medication the reason and how often it is taken.

______________________________________________________________

Do you take any over-the-counter medications? If yes, list the medication the reason and how often it is taken.

______________________________________________________________

Allergies And Adverse Reactions

If you have had an adverse reaction to medication, chemicals, insect bites, insecticides, foods, etc., please list with an explanation of your reaction and the severity:
Pregnancy History

How many times have you been pregnant (include miscarriages & abortions)?

# term deliveries _____ # of preterm deliveries _____ # of miscarriages _____ # of ectopic pregnancies _____

# of therapeutic abortions _____

Please complete the following for each pregnancy:

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome* (Use key below)</th>
<th>How Long to Encourage?</th>
<th>Father Current/Past</th>
<th>Sex</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Pregnancy</td>
<td>______</td>
<td>______</td>
<td>C P</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>2nd Pregnancy</td>
<td>______</td>
<td>______</td>
<td>C P</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>3rd Pregnancy</td>
<td>______</td>
<td>______</td>
<td>C P</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>4th Pregnancy</td>
<td>______</td>
<td>______</td>
<td>C P</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>5th Pregnancy</td>
<td>______</td>
<td>______</td>
<td>C P</td>
<td></td>
<td>______</td>
</tr>
</tbody>
</table>

* Vaginal delivery (V), C-Section (CS), Miscarriage (M), Abortion (A), Ectopic Pregnancy (EP)

Were there any complications during or after your pregnancies?

Please check if you have ever had:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterus removed</td>
<td></td>
</tr>
<tr>
<td>Uterine fibroids</td>
<td></td>
</tr>
<tr>
<td>Uterine Polyp(s)</td>
<td></td>
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<tr>
<td>Uterine hyperplasia</td>
<td></td>
</tr>
<tr>
<td>Uterine cancer</td>
<td></td>
</tr>
<tr>
<td>D&amp;C</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td></td>
</tr>
<tr>
<td>Ovaries removed</td>
<td></td>
</tr>
<tr>
<td>Ovarian cysts</td>
<td></td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td></td>
</tr>
<tr>
<td>Endometriosis</td>
<td></td>
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<tr>
<td>Pelvic Pain</td>
<td></td>
</tr>
<tr>
<td>PID</td>
<td></td>
</tr>
<tr>
<td>Pain with intercourse</td>
<td></td>
</tr>
<tr>
<td>Polycystic ovarian syndrome (PCOS)</td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td></td>
</tr>
<tr>
<td>Hot flashes</td>
<td></td>
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<tr>
<td>Vaginal dryness</td>
<td></td>
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<tr>
<td>Cervix frozen</td>
<td></td>
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<tr>
<td>Cervical biopsy</td>
<td></td>
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<tr>
<td>LEEP of cervix</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer</td>
<td></td>
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<tr>
<td>Vulvar cancer</td>
<td></td>
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<tr>
<td>Genital Warts</td>
<td></td>
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<tr>
<td>Genital herpes</td>
<td></td>
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<tr>
<td>Gonorrhea</td>
<td></td>
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<tr>
<td>Chlamydia</td>
<td></td>
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<tr>
<td>Trichomonas</td>
<td></td>
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<tr>
<td>Syphilis</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma</td>
<td></td>
</tr>
<tr>
<td>Yeast Infection</td>
<td></td>
</tr>
</tbody>
</table>

Do you use any contraception?  Y [ ]  N [ ]  If yes, please list: ____________________________

What contraception have you used in the past? Please check all that apply.

<table>
<thead>
<tr>
<th>Method</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Rhythm</td>
<td></td>
</tr>
<tr>
<td>Birth control patches</td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
</tr>
<tr>
<td>Sponge</td>
<td></td>
</tr>
<tr>
<td>Depo-Provera injection</td>
<td></td>
</tr>
<tr>
<td>Tubal ligation</td>
<td></td>
</tr>
<tr>
<td>Condoms</td>
<td></td>
</tr>
<tr>
<td>Norplant/implants</td>
<td></td>
</tr>
<tr>
<td>Birth control pills</td>
<td></td>
</tr>
<tr>
<td>Nuvaring</td>
<td></td>
</tr>
<tr>
<td>Foam/jellies</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td></td>
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Date of your last mammogram _______ Was it normal?  Y [ ]  N [ ]

Have you or do you currently have?  Breast Cancer  Augmentation  Fibrocystic Breasts  Nipple discharge  Breast Lump(s) removal  Reduction surgery

How often do you examine your breasts? _______

Date of last Pap smear: _______ Was it normal?  Y [ ]  N [ ]

Have you had abnormal Pap smears?  Y [ ]  N [ ]  If yes, when and what was the abnormality? ____________________________
What is the frequency of your sexual activity? _____/week _____/month

Do you have pain with sexual intercourse? Y □ N □

Do you or your partner use lubricants when engaged in sexual activity? Y □ N □

What is your sexual orientation? Heterosexual □ Lesbian □ Bisexual □

Have you ever been abused sexually, physically or emotionally? Y □ N □

**Surgical History**

Please list any type of surgery you have had:

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<tr>
<th>Type of Surgery</th>
<th>date</th>
<th>year</th>
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**Medical History** (Please check all that apply)

- abdominal aneurysm
- abnormal chest x-ray
- abnormal kidney
- AIDS
- alcoholism/alcohol trouble
- anemia
- asthma
- angina (chronic heart pain)
- bleeding problem
- blood clots
- cataracts
- chronic back pain
- colon cancer
- colon polyps
- contact lenses/glasses
- degenerative arthritis
- dentures
- depression
- diabetes
- drug abuse
- eating disorder
- eczema
- emphysema
- fecal incontinence
- gallstones
- glaucoma
- gout
- hay fever
- hearing loss
- heart attack
- heart murmur
- hepatitis/liver disease
- hemorrhoids
- herniated disc
- hiatal hernia
- high blood pressure
- high cholesterol
- HIV positive
- irritable bowel
- kidney stones
- leukemia
- lung cancer
- migraines
- pacemaker
- pancreatitis
- psoriasis
- rheumatic fever
- rheumatoid arthritis
- seizures
- skin cancer
- spastic colon
- stroke/TIA
- thyroid problems
- tuberculosis
- ulcers
- ulcerative colitis

**Social History**

What is your occupation? __________________________

What is your ethnic heritage? __________________________

(German, Italian, African-American, Ashkenazi, Jewish, etc.)

What do you do for exercise? __________________________

How many days/week? _____ How many minutes? _____

Do you smoke? Y □ N □

How many years did you or have you smoked? _____

When did you quit? _____

How much alcohol do you drink? _______ per day _______ per week _______ per month

Have you considered suicide? Y □ N □

Have you attempted suicide? Y □ N □

If yes, which ones? __________________________

Do you use any recreational drugs? Y □ N □

If yes, which ones? __________________________

How much caffeine do you drink per day? Coffee _______ Tea _______ Soda _______

Do you follow a special diet? Y □ N □

If yes, what kind? __________________________

Do you or have you had an eating disorder? Y □ N □

If yes, what kind? __________________________
Do you take calcium supplements?  Y ☐  N ☐  If yes, what kind and how much? ___________
Do you take vitamins or other supplements?  Y ☐  N ☐  If yes, what kind and how much? ___________

What is your religious affiliation? ___________  Do you observe religious traditions?  Y ☐  N ☐
If yes which ones? ___________
Have you ever received a blood transfusion?  Y ☐  N ☐  If yes, why? ___________
Have you been turned down as a blood donor?  Y ☐  N ☐  If yes, why? ___________
What is your blood type? ____  Height _____  Weight _____
Have you traveled to a foreign country within the last year?  Y ☐  N ☐  If yes, what country? _______

Are you immune to rubella (German measles)?  Y ☐  N ☐  Unknown ☐
Have you had the Chicken Pox or the vaccine series?  Y ☐  N ☐  Unknown ☐

**Family Cancer History**
Have you had any relatives with any form of cancer?  Y ☐  N ☐  If yes, please list who and what type of cancer:

**Family Tree**
Please list the names and ages of your immediate relatives. Also, please list any health problems that your relatives may have/had. If deceased, please indicate age at death, cause of death and any other health problems. If adopted please check the box to the right and skip to the next section.

Mother’s name: _________________  Present age? ____  Age at death? ____  Health problems and/or cause of death: ___________________________

Maternal Grandmother’s name: _________________  Present age? ____  Age at death? ____  Health problems and/or cause of death: ___________________________

Maternal Grandfather’s name: _________________  Present age? ____  Age at death? ____  Health problems and/or cause of death: ___________________________

Father’s name: _________________  Present age? ____  Age at death? ____  Health problems and/or cause of death: ___________________________

Paternal Grandmother’s name: _________________  Present age? ____  Age at death? ____  Health problems and/or cause of death: ___________________________

Paternal Grandfather’s name: _________________  Present age? ____  Age at death? ____  Health problems and/or cause of death: ___________________________
Please list all of your siblings and children:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Present Age If living</th>
<th>Age at death</th>
<th>Health problems and/or cause of death</th>
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Please give details of any family history you think may be relevant to your situation:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Fertility History and Therapy
These questions are specific to your fertility evaluation. If unsure of an answer, please leave blank.

How long have you been with your current partner? _________

How long have you been having unprotected sexual intercourse? _________

How long have you been trying to conceive? _________ Have you attempted to conceive a pregnancy with a prior partner? Y [ ] N [ ]

If yes, were you successful? _________

Have you had ultrasounds to look for ovulation? Y [ ] N [ ] Don't know [ ]

Have you had intrauterine inseminations? Y [ ] N [ ] Partner sperm? Y [ ] N [ ]

Donor sperm? Y [ ] N [ ] How many cycles? _____ How many per cycle? _____
If applicable, please check all of the following medications that you have taken in the past in an attempt to conceive:

Clomiphene Citrate- How many cycles? ______  What strength? ______  How many days? ______
Letrazole (Femara)- How many cycles? ______  What strength? ______  How many days? ______
HMG (Repronex, Follistim, Gonal-F, Bravelle, Menopur) How many cycles?
hCG (Profasi, Pregnyl, Novapal, Ovidrel)
Estrogens (Premarin, Estrace, Estratest, Ogen)
Bromocriptine (Parlodel, Dostinex)
Danazol (Danocrine)
Antibiotics
Progesterone suppositories/oral progesterone injection/vaginal progesterone
Prednisone
GnRH agonists (Lupron, Ganerelix, Cetrelide)
Other
Never utilized fertility medications

Have you had any of the following tests/procedures performed? (check all that apply)

Temperature charts  X-ray of fallopian tubes
Clomid Challenge test  (HSG or Hysterosalpingogram)
AMH (Anti Mullerian hormone) Sonohysterogram (Saline ultrasound)
Day 3 FSH and Estradiol  Endometrial Biopsy
Blood Tests  Hysteroscopy
Chromosomal analysis
Gynecologic Surgery (Laparoscopy, myomectomy, etc.) Findings?
Ovulation predictor kits
IVF (In vitro fertilization) Number of IVF cycles? ______  How many eggs obtained? ______  Number of embryos transferred? ______  Embryos Frozen ______
How many fertilized? ______

Have any pregnancies resulted from any fertility treatments?  Y [ ]  N [ ]

If yes, which treatment and what was the outcome? ____________________________________________
INFECTIONOUS DISEASE SCREENING QUESTIONNAIRE - FEMALE

At Albrecht Women’s Care, we offer infectious disease screening for all patients. Please answer the following questions to help us understand your risk of having been exposed to certain infectious diseases.

Yes No

___ ___ Were you born in Haiti or sub-Saharan Africa?

___ ___ Are you of Asian, Pacific Island, or Alaskan Eskimo descent, whether born in the United States or mainland or in the above-mentioned areas?

Do you have a history of:

___ ___ Acute or chronic liver disease?

___ ___ Work or treatment in a hemodialysis unit?

___ ___ Rejection as a blood donor?

___ ___ Blood transfusion on repeated occasions?

___ ___ Frequent occupational exposure to blood in medical or dental settings?

___ ___ Household contact with a hepatitis B carrier or hemodialysis patient?

___ ___ Three or more episodes of sexually transmitted diseases?

___ ___ Use of social drugs that you have injected into yourself using a needle?

NAME (Please print): ________________________________

SIGNATURE: ______________________ DATE: ____________________