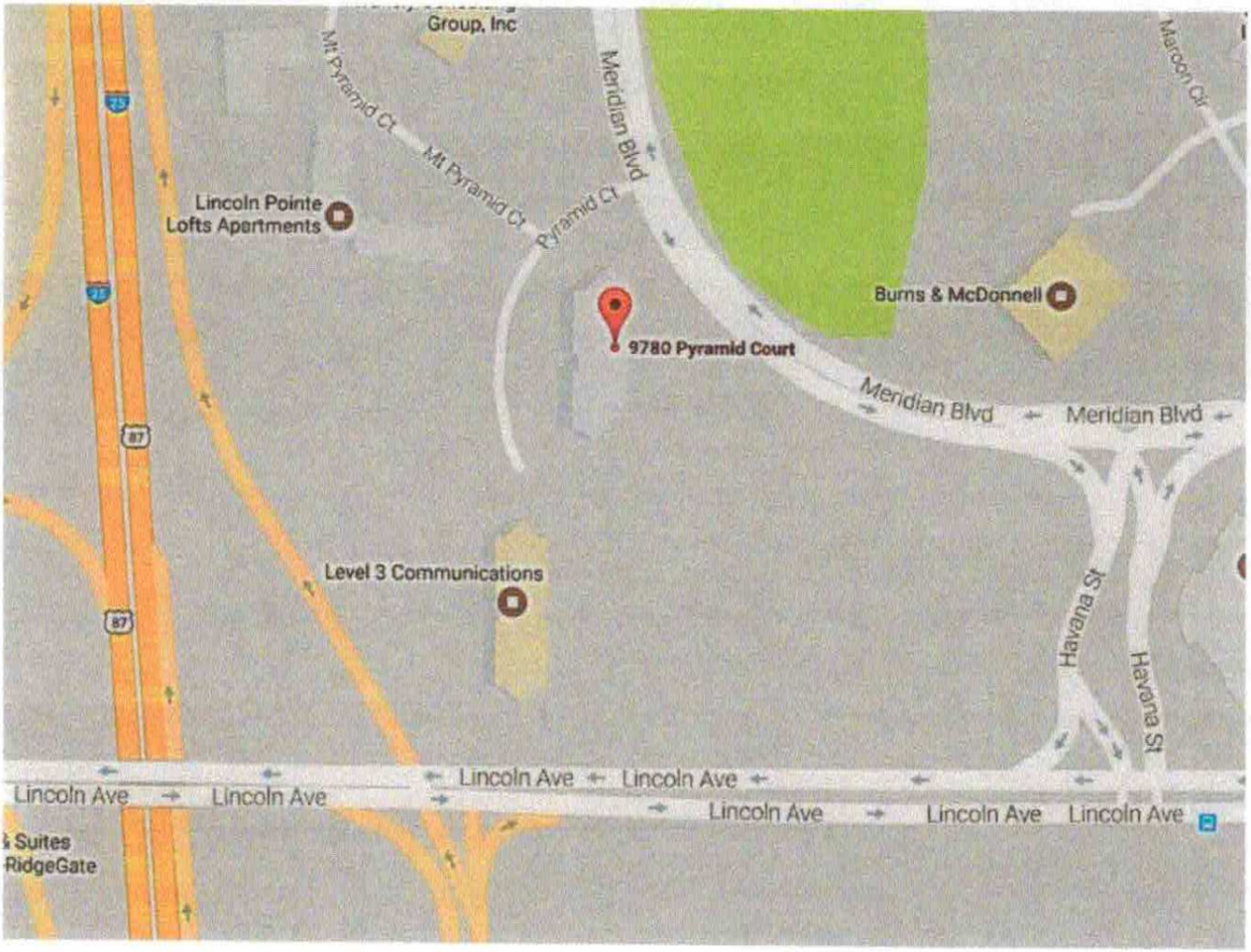
Directions to Denver Fertility/Albrecht Women's Care

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 REGISTRATION FORM

PATIENT INFORMATION

Name: _____ **DOB:** _____
First M.I. Last

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: _____
Claims Address: _____
_____
Phone Number: _____
ID Number: _____
Group Number: _____
Effective Date: _____
Policy Holder Name: _____
DOB: _____
SSN: _____

Secondary Insurance: _____
Claims Address: _____
_____
Phone Number: _____
ID Number: _____
Group Number: _____
Effective Date: _____
Policy Holder Name: _____
DOB: _____
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:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence)
- Notifying your employer under limited circumstances related primarily to workplace injury, time off work, illness or medical surveillance

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.

Print Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

OPTIMIZING YOUR CHANCES FOR A HEALTHY PREGNANCY

Patient Name: _____ **DOB:** _____

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 sub-specialists 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 T_4), 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 bug 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 Spouse/Partner Name	Spouse/Partner Signature	Date
Print Witness Name	Witness Signature	Date

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

INFECTIOUS DISEASE TESTING

Infectious disease testing (IDT) is strongly recommended for all patients that seek fertility treatment. It affords a reduced risk to you, the patient, and to your unborn child. Infectious disease testing is required if you pursue In Vitro Fertilization (IVF).

IDT panels can be submitted to your insurance with a pre-conception medical code. This may allow IDT to be covered by your insurance plan, but we recommend that you check with your individual plan directly to verify coverage. Please ask our billing coordinators for any diagnosis and laboratory codes to give to your insurance company.

Female and Male Testing:

- HIV I/II
- Hepatitis B Surface Antigen and Hepatitis B Core Antibody
- Hepatitis C Antibody
- RPR with reflex titers
- Gonorrhea and Chlamydia
- Blood type and RH factor
- Complete Blood Count
- Cytomegalovirus Antibody
- Rubella and Varicella Immunity Status (female only)
- HTLV (male only)

I have read the above paragraph and understand that it is recommended to screen for infectious diseases as part of my fertility evaluation.

PATIENT

□ **Accept**

□ **Decline** _____ Print Patient Name _____ Patient Signature _____ Date

SPOUSE/PARTNER

□ **Accept**

□ **Decline** _____ Print Spouse/Partner Name _____ Spouse/Partner Signature _____ Date

GENETIC CARRIER SCREENING

Genetic carrier screening is strongly recommended for all patients that seek fertility treatment.

Genetic screening is a powerful tool that can determine if you or your partner is a carrier of an inherited genetic condition. You can be a carrier without having the condition itself — in fact many people may carry genetically inherited conditions — any one of which we can pass on to our children. You could be a carrier of a common genetic condition without even knowing it. Regardless of your family history, ethnicity, age, or personal health, the only way to know for sure is to be screened.

The ideal time to undergo carrier screening is prior to pregnancy. By doing so, you can get information to help you plan your reproductive journey. However, even couples who are already pregnant can benefit from what screening can reveal.

Denver Fertility screens for all the diseases that are recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American College of Medical Geneticists (ACMG).

Denver Fertility uses NxGenMDx for genetic carrier screenings. Please refer all billing inquires to NxGen MDx directly. For additional information on NxGenMdx and their company or a list of diseases that are tested, go directly to their website at: www.nxgenmdx.com

If you or your partner should test positive for a specific genetic disorder, you will have a consultation with a genetic counselor to discuss your results.

The decision to consider or refuse genetic testing is entirely my decision. I understand that no screening is 100% reliable. I understand and accept the consequences of this decision. My signature below indicates that I have had the opportunity to discuss this information with my doctor or someone designated by my physician. Also, I know that I may obtain professional genetic counseling if I wish before or after signing this consent.

I have read the above paragraph and understand that it is recommended to screen for infectious diseases as part of my fertility evaluation.

PATIENT

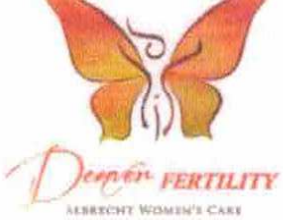
□ **Accept**

□ **Decline** _____ Print Patient Name _____ Patient Signature _____ Date

SPOUSE/PARTNER

□ **Accept**

□ **Decline** _____ Print Spouse/Partner Name _____ Spouse/Partner 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: ___ Marital 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:

	Year	Outcome* (Use key below)	How Long to to Conceive?	Father Current/Past		Sex	Weight
1st Pregnancy	____	____	____	C	P	___	_____
2nd Pregnancy	____	____	____	C	P	___	_____
3rd Pregnancy	____	____	____	C	P	___	_____
4th Pregnancy	____	____	____	C	P	___	_____
5th Pregnancy	____	____	____	C	P	___	_____

* 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:

Uterus removed
Uterine fibroids
Uterine Polyp(s)
Uterine hyperplasia
Uterine cancer
D&C
Hysteroscopy
Ovaries removed
Ovarian cysts
Ovarian cancer

Endometriosis
Pelvic Pain
PID
Pain with Intercourse
Polycystic ovarian syndrome (PCOS)
Infertility
Hot flashes
Vaginal dryness

Cervix frozen
Cervical biopsy
LEEP of cervix
Cervical cancer
Vulvar cancer

Genital Warts
Genital herpes
Gonorrhea
Chlamydia
Trichomonas
Syphilis
Mycoplasma
Yeast Infection

Do you use any contraception? Y ☐ N ☐ If yes, please list: _____

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

None
Rhythm
Birth control patches
Diaphragm

Sponge
Depo-Provera injection
Tubal ligation
Condoms

Norplant/implants
Birth control pills
Nuvaring

Foam/jellies
Withdrawal
IUD

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:

Type of Surgery	date	year	Type of Surgery	date	year
_____	____	____	_____	____	____
_____	____	____	_____	____	____

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 ☐

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:

Name	Relationship	Present Age If living	Age at death	Health problems and/or cause of death

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, Novaral, Ovidrel)
Estrogens (Premarin, Estrace, Estratest, Ogen)
Bromocriptine (Parlodel, Dostinex)
Danazol (Danocrine)
Antibiotics
Progesterone suppositories/oral progesterone injection/vaginal progesterone
Prednisone
GnRH agonists(Lupron, Ganerelix, Cetritide)
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 Hysterosalpingorgram)
AMH (Antimullerian 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? _____
How many fertilized? _____ Number of embryos transferred? _____ Embryos Frozen _____

Have any pregnancies resulted from any fertility treatments? Y ☐ N ☐

If yes, which treatment and what was the outcome? _____

Denver FERTILITY
ALBRECHT WOMEN'S CARE

INFECTIOUS DISEASE SCREENING QUESTIONNAIRE - FEMALE

At Denver Fertility 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?

Print Patient Name: _____

Patient Signature: _____ Date: _____