Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK
Women's Care of Alaska
Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

PATIENT:

Patient Name _____ DOB _____ SS# _____

Preferred Ph# _____ _____ Other # _____ _____Email_____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address_____ City _____ State ____ Zip _____

Relationship Status _____Gender Identity _____Sexual Orientation _____

Race _____ Ethnicity _____

How did you hear about our practice? _____

PARTNER:

Partner Name _____ DOB _____ SS# _____

Preferred Ph# _____ _____ Other # _____ _____ Email _____

Mailing Address _____ City _____ State ____ Zip _____

Employer Name _____ Occupation _____

Employer Address_____ City _____ State ____ Zip _____

IF PATIENT IS A MINOR

Who may authorize treatment? _____ *Relationship* _____ *Contact#:* _____ _____

INSURANCE:

PRIMARY INSURANCE COMPANY: _____

Subscriber Name_____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name_____

Employer Address_____ City _____ State ____ Zip _____

SECONDARY INSURANCE COMPANY: _____

Subscriber Name_____ DOB _____ SS# _____

Subscriber ID# _____ Group# _____ Relationship to Patient _____

Employment Status _____ Occupation _____ Employer Name _____

Employer Address_____ City _____ State ____ Zip _____

EMERGENCY CONTACT:

Emergency Contact Name _____ Relationship _____ Ph# _____ _____

Emergency Contact Name _____ Relationship _____ Ph# _____ _____

AUTHORIZATION Please initial each line, and sign the bottom

_____ I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care.

_____ I authorize direct payment to the provider(s) for my medical and/or surgical care.

_____ I understand that I am responsible to pay any non-covered charges or services.

_____ I understand that if I am uninsured, I am responsible to pay for any services provided.

_____ I have read and agree to the PATIENT FINANCIAL POLICY for Women's Care of Alaska.

_____ _____

Patient Signature Date

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK
Women's Care of Alaska
Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

Effective Date: January 23, 2014

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please call our office with any questions or concerns.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of Protected Health Information (PHI).
- Provide notice of our legal duties and privacy practices regarding Health Information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use disclosed Health Information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we my use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, if they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law enforcement agencies.

***To Avert a Serious Threat to Health or Safety*:** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However, disclosures will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking, transportation of organs eyes or tissues to facilitate organ, eye or tissue donation and transportation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and relicensing. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be a result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary; 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT-OUT.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy health information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this health information, you must make your request, in writing, to Women's Care of Alaska, at the address listed on page one. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request under certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review.

Right to an Electronic Copy of Electronic Medical Records: If your protected health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health Information in the form or format you request, if it is readily available in such form or format. If the Protected Health Information is not readily available in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy. We may charge you a reasonable, cost-based fee for the labor associated with transmitting or printing the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend: If you feel that the health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Women's Care of Alaska, at the address listed on page one.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of your Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization . To request an accounting of disclosures, you must make your request, in writing to Women's Care of Alaska at the address listed on page one.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Women's Care of Alaska on our Disclosure Form. We are not required to agree to your request unless you are asking us to restrict the use and dis closure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments: If you paid out-of-pocket (or, in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not to be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For Example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing to our office, at the address listed on page one. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask any of our receptionists to make you a copy.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and can be sent to Women's Care of Alaska at the address listed on page one. If you have questions, please contact our office at 907-279-2273. ***You will not be penalized for filing a complaint.***

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK
Women's Care of Alaska

Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the:
Patient's Printed Name

Women's Care of Alaska's Notice of Privacy Practices

_____ _____
Signature of Patient Date

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK
Women's Care of Alaska

Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

CONSENT TO TREAT AND PAYMENT RESPONSIBILITY

The undersigned consents to medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to, laboratory procedures, ultrasounds, medical or surgical treatment, or procedures, or other services rendered to the patient under the general and special instructions of the physician or provider.

The undersigned understands that Women's Care of Alaska (WCAK) has agreed to bill my insurance as a courtesy. In order to process such payments and obtain procedure authorizations, WCAK may disclose any or all my medical record to medical service companies, insurance companies, or workman's compensation carriers, as necessary. The undersigned authorizes all insurance carriers, with whom I have coverage, including Medicare, Medicaid, and Tricare, to assign all payment of benefits due under the terms of my policy, to **Women's Care of Alaska,** including any settlements or judgments for such items or services. The undersigned agrees to notify WCAK of any changes in my insurance coverage, as soon as possible, to ensure there is no delay in billing. If, for some reason, my health insurance sends payment directly to me, I agree to immediately forward all payments that I have received for my care, and treatment, to WCAK. I understand and agree that I have been advised that I may be billed by WCAK and that this Assignment of Benefits and Agreement to Pay applies to any and all WCAK physician services, including both inpatient and outpatient charges, performed by my provider.

The undersigned understands that some items or services provided may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services in excess of the limits in my member benefit agreement. I understand that I am personally responsible for any item or service determined by my insurance company to be experimental, investigational, or to be non-covered for any other reason. I understand that I am personally responsible for any non-covered Medicare, Medicaid, Tricare items or services that are listed on the financial responsibility for non-covered items or services form. I am responsible for all copays, deductibles, and coinsurance established by my member benefit agreement.

The undersigned understands and agrees that all account balances are **due within 30 days of billing**. I also understand that if my account becomes delinquent, the account will be referred to an outside collection agency for payment resolution. If my account is referred to an outside collection agency, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

_____ Date: _____

(Printed Name of Patient, Parent, or Guardian)

_____

Patient, Parent, Guardian Signature:

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK
Women's Care of Alaska

Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

PATIENT PORTAL

In the Summer of 2018, we launched our online Patient Portal with www.myhealthrecords.com. The implementation of this new system allows us to send automated appointment reminders / messages. Please provide your most current information below, so what we may ensure timely and accurate delivery of appointment reminders/messages:

CURRENT EMAIL ADDRESS:

_____

PREFERRED PHONE NUMBER FOR CONTACT:

Home * Mobile * Business

(_____)_____- _____

PREFERRED METHOD TO RECEIVE REMINDERS/ MESSAGES

(Please ONLY circle the ways you wish to receive all your appointment reminders/messages.)

Voice Call * Text * Email* Do Not Contact for Reminders

Additionally, the Patient Portal will allow you the ability to request appointments, directly and securely message your provider, view your medical records, and much more. Activating your Patient Portal is simple. We will send you an email invitation, simply follow the instructions in the email to set up your Patient Portal Account.

_____ _____

Patient Printed Name Date

_____

Patient Signature

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK Women's Care of Alaska
Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

PATIENT NAME: _____ DOB: _____
Month Day Year

AUTHORIZED METHODS OF COMMUNICATION
(√ Check all that apply)

☐ **RESIDENCE TELEPHONE**	☐ **CELL PHONE**	☐ **WORK TELEPHONE**
Number: ( ) _____	Number: ( ) _____	Number: ( ) _____
☐ Leave a call back number only. Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message	☐ Leave a call back number only; Do NOT leave a message
☐ OK to leave detailed message with person	☐ OK to leave detailed message with person	☐ OK to leave detailed message with person
☐ OK to leave detailed message on voicemail	☐ OK to leave detailed message on voicemail	☐ OK to leave detailed message on voicemail

Do you authorize us to speak with another individual, such as a spouse/partner, or other relative, regarding your PHI? If so, please write their name down below, along with their relationship to you. This information can be changed any time you request a change. Forms of PHI include, but are not limited to, the following examples:

(T) Treatment
Test results
Prescriptions/refills
Treatment Options

(P) Payment
Insurance questions/problems
Account balance/payment options

(O) Healthcare Operations Activities
Appointment reminder, Messages returned
Referral options/appointments, Records release
Messages that results are available

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

Name: _____/_____ (T) (P) (O) Circle all that apply
PLEASE PRINT (RELATION TO PATIENT)

PATIENT SIGNATURE: _____ DATE:_____

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK
Women's Care of Alaska

Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

INFORMED CONSENT – TELEMEDICINE APPOINTMENT

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through use of interactive video, audio, or other telecommunication technology. Additionally, a physical examination of you may take place, and video, audio and/or photo recordings may be taken.

ANTICIPATED BENEFITS:

- Improved access to medical care by enabling a patient to remain in their location while the healthcare provider provides care from a distant site.
- Limiting the spread of COVID-19.
- More efficient medical evaluation and management.

POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- It may be determined that that information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation / treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all your medical records may result in adverse drug reactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
- I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed without my authorization.
- I understand that during the COVID-19 Pandemic, security measurements may be lessened in accordance with U.S. Department of Health and Human Services to ensure improved access to care.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time without affecting my right to future care or treatment.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
- I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I understand that I am still responsible for any co-payments or co-insurance that may apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost(s), I will be responsible for payment.

I have read and understand the information provided above regarding telemedicine:

☐ I ***DO*** consent to Telemedicine Appointments.

☐ I ***DO NOT*** consent to Telemedicine Appointments.

_____ _____

PRINTED NAME DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE OF BIRTH

Kristina Eaton, MD
Allison van Haastert, MD
Jessica Goldberger, MD
Meagan Byrne, DO

WC AK Women's Care of Alaska

Wynd Counts, MD * Wendy Cruz, MD

Katie Ulmer, ANP
Migel Hadley, ANP
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 * (907)279-2273 Fax (907)258-7705 www.wcakobgyn.com

Medical and Reproductive History – Infertility

Today's date: _____/_____/_____

***Female Patient*:**
(LEGAL) Last name: _____ **(LEGAL)** First name: _____ Middle initial: _____

Age: _____ Date of birth: _____/_____/_____

Marital status: _____ single _____ married _____ domestic partner Length of relationship: _____years

***Partner*:**
(LEGAL) Last name: _____ **(LEGAL)** First name: _____ Middle initial: _____

Age: _____ Date of birth: _____/_____/_____

Reason for visit: _____

Fertility History – Female Patient

Do you have any theories as to why you have been unable to conceive? _____

How long have you been trying to conceive? _____

***Pregnancy History*:** List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Pregnancy ended (mo. / yr.)	Pregnancy length (weeks, months)	Outcome	Father (check one)	
				Present partner	Previous partner

***Previous Fertility Evaluation*:** List any previous testing or procedures you have had done. _____

_____

_____

_____

Reproductive Health History – Female Patient

***Menstrual History*:**

Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: _____/_____/_____

Menstrual cycle pattern without hormone or oral contraceptive pills (OCP's) – (check all that apply):

☐ Regular periods ☐ Irregular periods ☐ Heavy periods ☐ Light periods
☐ No periods ☐ Spotting between periods

How many days from the first day of one period to the first day of the next? _____ days

How many days of bleeding do you usually have? _____ days

Do you need medication to bring on a period? ☐ Yes ☐ No If Yes, what type? _____

Do you have cramping or pelvic pain with your periods? (check one)

☐ Always ☐ Sometimes ☐ Recently ☐ In the past
☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? _____/_____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, date and treatment: _____/_____ _____

Contraceptive Method History:

Type	Years used
☐ Birth control pills / Patch	
☐ Depo Provera, Lunelle	
☐ Nuva Ring	
☐ Norplant / Implanon / Nexplanon	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal sterilization	
☐ Vasectomy	
☐ Rhythm method	
☐ Other	

Sexual History:

How many times per week do you have intercourse? _____

How many times do you have intercourse mid-cycle? _____

Do you experience any pain with intercourse? ☐ Yes ☐ No

Do you regularly use lubricant with intercourse? ☐ Yes ☐ No If yes, what type? _____

Have you ever had any sexually transmitted infections? (check all that apply)

☐ Chlamydia	☐ Gonorrhea	☐ Herpes	☐ Syphilis
☐ Genital Warts	☐ Trichomonas	☐ HIV	☐ HPV
☐ Hepatitis	☐ Other _____		

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No If yes, when? _____

Were you hospitalized? ☐ Yes ☐ No

Has anyone close to you, ever threatened to, or physically hurt you? ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No

Do you fear harm from anyone at home, or school, or anywhere else? ☐ Yes ☐ No

General Medical History – Female Patient

What is your current weight? _____ Height? _____ Usual weight? _____

Have you had recent weight loss or gain in the past 6 months? ☐ Yes ☐ No

Are you currently being treated or being seen for any medical condition(s)? ☐ Yes ☐ No

If yes, describe: _____

_____

***Review of systems*:** Check any of the following that you are presently having or have had in the past:

Eye problems ☐	Gall bladder problems ☐	Excessive thirst ☐
Stuffy nose or hay fever ☐	Liver disease ☐	Temperature intolerance ☐
Frequent nose bleeds ☐	Frequent urination at night ☐	Headaches ☐
Fast or irregular heartbeat ☐	Vaginal discharge, itching, pain ☐	Shaking or tremor ☐
Heart murmur ☐	Pelvic pain ☐	Anxiety ☐
Mitral valve prolapse ☐	Sexual problems ☐	Depression ☐
Dizziness or fainting ☐	Endometriosis ☐	Bulimia or anorexia ☐
Shortness of breath ☐	Ovarian tumor ☐	Anemia ☐
Lung disease ☐	Dark skin on neck or armpits ☐	Easy bleeding or bruising ☐
Asthma ☐	Acne or pimples ☐	Poor circulation ☐
Tuberculosis ☐	Enlarged or painful breast ☐	Blood transfusion ☐
Heartburn or indigestion ☐	Discharge from nipples ☐	Fatigue ☐
Gas, cramps or pain ☐	Breast lumps ☐	Low energy ☐
Blood in stool or black stool ☐	Breast disease ☐	Past history of IV drug use ☐
Nausea or vomiting ☐	Hot flashes ☐	Rubella (German measles) ☐

Constipation	☐	Excessive face or body hair	☐	Other	☐
Diarrhea	☐	Hair thinning or loss	☐		☐
Hernia	☐	Fever, sweats or chills	☐		☐

Explain any positive responses: _____

_____

_____

Surgical History: List any major illnesses, surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

Date (month / year)	Procedure	Reason

***Current Medications*:** List all medications (including vitamins, herbs and over the counter medications) or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

***Allergies*:** List all drug, environmental and food allergies:

Allergy	Reaction

Social History – Female Patient

Current occupation: _____

Have you or do you partake in any of the following?

	Never	Not in the last 3 months	Yes	List type, amount and frequency (how often / per day or week)
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Caffeine	☐	☐	☐	

Social Drugs	☐	☐	☐	
Exercise	☐	☐	☐	

Family and Genetic Health History – Female Patient

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, describe: _____

Are you adopted? ☐ Yes ☐ No

Are you of any of the following ethnic backgrounds? (check all that apply)

☐ Ashkenazi Jewish ☐ Mediterranean ☐ Middle Eastern ☐ Asian
☐ African ☐ Hispanic or Caribbean ☐ French Canadian of Cajun ☐ Caucasian

Have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
α (alpha) thalassemia	☐ Yes ☐ No	
β (beta) thalassemia	☐ Yes ☐ No	
Sickle Cell Anemia	☐ Yes ☐ No	
Tay Sach's Disease	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Spinal Muscular Atrophy	☐ Yes ☐ No	

If you are of Eastern European Jewish (Ashkenazi) ancestry, have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
Canavan Disease	☐ Yes ☐ No	
Familial Dysautonomia	☐ Yes ☐ No	
Fanconi Anemia	☐ Yes ☐ No	
Neimann-Pick Disease	☐ Yes ☐ No	
Mucolipidosis Type IV	☐ Yes ☐ No	
Bloom Syndrome	☐ Yes ☐ No	
Gaucher Disease	☐ Yes ☐ No	

Indicate which of the following conditions may be found in your family:

Medical Condition	Self	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Your children	Other relatives
		M	F	S	B	GM	GF	GM	GF		
Autoimmune disorder, such as lupus or rheumatoid arthritis											
Birth defects requiring surgery (cleft lip, etc.)											
Bleeding disorders (hemophilia, etc.)											
Blindness											
Bone Disorder											
Cancer before age 50 (Specify)											

Chromosome disorders (Down syndrome, Klinefelter syndrome)											
Clotting disorders (Factor V Leiden, etc.)											
Deafness											
Diabetes (insulin dependent)											
Endocrine disorders (thyroid disorders, adrenal hyperplasia, etc.)											
Epilepsy											
Heart defects ("hole in the heart", etc.)											
Heart Disease											
High blood pressure											
High cholesterol											
Hydrocephaly ("water on the brain")											
Kidney disease											

Medical Condition	Self	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Your children	Other Relatives
		M	F	S	B	GM	GF	GM	GF		
Limb defects (missing or extra fingers or toes, shorten arms or legs)											
Marfan Syndrome											
Mental illness (schizophrenia, bipolar, etc.)											
Mental retardation, autism or learning disabilities											
Muscular dystrophy											
Neurofibromatosis											
Neurologic or neurodegenerative disease (Alzheimer, Huntington, etc.)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Phenylketonuria (PKU)											
Polycystic kidney disease											
Skin diseases (eczema, melanoma)											
Stillbirth of children who have died as infants											
Stroke											
Thalassemia (Cooley's anemia)											
Unusual genitals in boys or girls											
Urinary tract abnormalities											
Women who have had multiple miscarriage											
Other serious health issues											

Explain any positive responses: _____

_____

_____

Fertility History – Partner

Do you have any theories as to why you have been unable to conceive? _____

_____

***Pregnancy History*:** List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Pregnancy ended (mo. / yr.)	Pregnancy length (weeks, months)	Outcome	Father (check one)	
				Present partner	Previous partner

Have you ever been unable to conceive with anyone other than your current partner? ☐ Yes ☐ No

Have you ever consulted a urologist or male infertility specialist? ☐ Yes ☐ No If yes, when? _____/_____

Reason: _____

Findings / Recommendations: _____

_____

***Previous Fertility Evaluation*:** List any previous testing or procedures you have had done. _____

_____

General Medical History – Partner

Surgical History: List any major illnesses, surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

Date (month / year)	Procedure	Reason

***Current Medications*:** List all medications (including vitamins, herbs and over the counter medications) or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

Social History – Partner

Current occupation: _____

Have you or do you partake in any of the following?

	Never	Not in the last 3 months	Yes	List type, amount and frequency (how often / per day or week)
Tobacco	☐	☐	☐	

Alcohol	☐	☐	☐	
Social Drugs	☐	☐	☐	
Caffeine	☐	☐	☐	
Exercise	☐	☐	☐	

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? ☐ Yes ☐ No

Family and Genetic Health History – Partner

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, describe: _____

Do any of your blood relatives (siblings, children, aunts, uncles, etc.) have a birth defect (e.g. mental retardation, spina bifida, heart abnormalities, etc.)? ☐ Yes ☐ No

If yes, describe: _____

_____

Are you adopted? ☐ Yes ☐ No

Are you of any of the following ethnic backgrounds? (check all that apply)

☐ Ashkenazi Jewish ☐ Mediterranean ☐ Middle Eastern ☐ Asian
☐ African ☐ Hispanic or Caribbean ☐ French Canadian of Cajun ☐ Caucasian

Have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
α (alpha) thalassemia	☐ Yes ☐ No	
β (beta) thalassemia	☐ Yes ☐ No	
Sickle Cell Anemia	☐ Yes ☐ No	
Tay Sach's Disease	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Spinal Muscular Atrophy	☐ Yes ☐ No	

If you are of Eastern European Jewish (Ashkenazi) ancestry, have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
Canavan Disease	☐ Yes ☐ No	
Familial Dysautonomia	☐ Yes ☐ No	
Fanconi Anemia	☐ Yes ☐ No	
Neimann-Pick Disease	☐ Yes ☐ No	
Mucolipidosis Type IV	☐ Yes ☐ No	
Bloom Syndrome	☐ Yes ☐ No	
Gaucher Disease	☐ Yes ☐ No	