

TEXAS CENTER FOR  
REPRODUCTIVE HEALTH

**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

\_\_\_\_\_  
Last First M.I.

\_\_\_\_\_  
Address City State Zip

Mobile#: \_\_\_\_\_ Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

Email: \_\_\_\_\_ May we email you? \_\_\_\_\_

Preferred # or method for confidential messages: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

United States Citizen: Yes / No

If no, list permanent mailing address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Telephone#: \_\_\_\_\_

**SPOUSE INFORMATION**

\_\_\_\_\_  
Last First M.I.

Mobile#: \_\_\_\_\_ Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

United States Citizen: Yes / No

If no, list permanent mailing address: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Texas Center for Reproductive Health reserves the right to modify the privacy practices outlined in the notice.

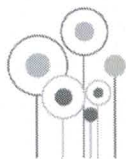
I, \_\_\_\_\_, have received a copy of privacy practices for The Texas Center for  
(print name)  
Reproductive Health.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print Name of Patient

\*\*Please read and initial each box

- ( ) I consent to treatment necessary for the care of the patient indicated on this form  
( ) I understand I am financially responsible for this account  
( ) Authorization is hereby granted to release info to me VERBALLY over the phone  
( ) Authorization is hereby granted to release info to my spouse (or other) over the phone: (name) \_\_\_\_\_



TEXAS CENTER FOR  
REPRODUCTIVE HEALTH

## PAYMENT AGREEMENT

Thank you for choosing the Texas Center for Reproductive Health as your healthcare provider. We are committed to providing the highest quality medical care.

Full payment is due at the time of service. TXCRH accepts cash, check, Visa, Mastercard, and Discover as method of payment. Prompt payment allows for the control of cost.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Our staff will make every effort to make the payment process as easy as possible.

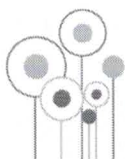
If you have any questions, please contact our business office immediately.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Drivers License Number

\_\_\_\_\_  
Expiration Date



TEXAS CENTER FOR  
REPRODUCTIVE HEALTH

Privacy Questionnaire

Please list the names of family members or other persons whom we may inform about your general medical condition and your diagnosis:

Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Please list the family members or significant others whom we may inform about your medical condition  
ONLY IN AN EMERGENCY:

Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home**:

\_\_\_\_\_  
\_\_\_\_\_

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information **if other than your home phone number**:

#: \_\_\_\_\_

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? YES \_\_\_\_\_ NO \_\_\_\_\_

If you do not have voicemail, can a confidential message be left at your place of employment?  
YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

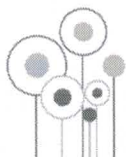
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Texas Center for Reproductive Health** reserves the right to modify the privacy practices outlined in this notice. I have received a copy of the Notice of Privacy Practices for **Texas Center for Reproductive Health**.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



**FERTILITY QUESTIONNAIRE – FEMALE**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Husband's Name: \_\_\_\_\_

**A. GENERAL INFORMATION:**

1) How long have you been married? \_\_\_\_\_

2) How long have you been seeking a pregnancy? \_\_\_\_\_

3) Is this your first marriage? **Yes / No**

4) Do you have children from this marriage? **Yes / No**

How many children? \_\_\_\_\_ Adopted \_\_\_\_\_ Biological \_\_\_\_\_

5) Do you have children from previous marriage(s) or relationship? **Yes / No**

How many children? \_\_\_\_\_ Adopted \_\_\_\_\_ Biological \_\_\_\_\_

**B. MENSTRUAL CYCLE:**

1) What age were you when your menses started? \_\_\_\_\_

2) Are your menses regular? **Yes / No** Number of days in cycle? \_\_\_\_\_

3) How many days of flow do you have in an average period? \_\_\_\_\_

4) What was the date of your last menstrual period? \_\_\_\_/\_\_\_\_/\_\_\_\_

6) Do you have spotting prior to the onset of a brisk menstrual flow? **Yes / No**

5) Do you have pain with your menstrual flow? **Yes / No**

6) How do you decide that ovulation is occurring? \_\_\_\_\_

7) Do you have pain when ovulating? **Yes / No**

8) Do you have bleeding near ovulation? **Yes / No**

9) What is your frequency of intercourse near ovulation? \_\_\_\_\_

10) Do you have mid-cycle bleeding? **Yes/ No**

11) Have you taken your basal body temperature during a menstrual cycle(s)?

**C. INTERCOURSE:**

- 1) How frequently do you have intercourse? \_\_\_\_\_
- 2) Do you use lubricants with intercourse? **Yes / No**
- 3) Do you use douches near intercourse? **Yes / No**
- 4) Do you have pain with intercourse? **Yes / No**

**D. PREVIOUS PREGNANCIES:**

- 1) How many times have you been pregnant? \_\_\_\_\_  
Dates? \_\_\_\_\_
- 2) What was the outcome and how many?  
\_\_\_\_ live birth [ \_\_\_\_ full term ( $\geq 37$  wks), \_\_\_\_ preterm ( $< 37$  wks)]  
\_\_\_\_ stillborn \_\_\_\_ therapeutic abortion  
\_\_\_\_ ectopic pregnancy \_\_\_\_ spontaneous abortion ( $< 20$  wks)
- 3) How long did it take to conceive in previous attempts at pregnancy? \_\_\_\_\_

**E. CONTRACEPTION:**

- 1) Have you previously used contraception? **Yes / No**  
If yes, what form(s) of contraception?  
( ) contraceptive pill ( ) intrauterine device  
( ) diaphragm ( ) other  
( ) condom
- 2) Surgical sterilization? **Yes / No** Date: \_\_\_\_\_

**F. MEDICAL-SURGICAL:**

- 1) Have you ever had surgery? **Yes / No**  
Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Place: \_\_\_\_\_
- 2) Have you recently lost or gained over 20 pounds? **Yes / No**
- 3) Do you exercise regularly? **Yes / No** If yes, how often and what type?
- 4) Do you follow any special dietary regimen? **Yes / No** If yes, what type?
- 5) Are you allergic to any medications? **Yes / No** If yes, please list:

6) Do you use or have used:

☐ Prescription drugs or medications

If yes, please list:

☐ Non-prescription drugs or medications

If yes, please list:

☐ Marijuana or other recreational drugs

☐ Tobacco products

What?

How much?

☐ Alcoholic beverages

What?

How much?

☐ Natural, herbal, multivitamin supplements?

What?

How often?

7) Do you have or ever had:

☐ Anemia

☐ Appendicitis

☐ Bronchitis

☐ Cancer

☐ Dizziness

☐ Endometriosis

☐ Gonorrhea

☐ Heart Disease

☐ Liver Problems

☐ Ovarian Cysts

☐ Pelvic Infection

☐ Thyroid Problems

☐ Visual Problems

☐ Excess Sweating

☐ Dyslipidemia (i.e. abnormal levels of cholesterol/lipids)

☐ Allergies

☐ Arthritis

☐ Chlamydia

☐ Colitis

☐ Headache

☐ Diabetes

☐ Hirsutism

☐ Herpes

☐ Syphilis

☐ Ulcers

☐ Vaginitis

☐ Hepatitis

☐ Immunizations

☐ HIV

☐ Auto Immune Disease

☐ Blood Product Transfusions

☐ Epilepsy (Seizures)

☐ Color Blindness

☐ Excess Body or Facial Hair

☐ Breast Discharge

☐ Intolerance to Heat or Cold

☐ High Blood Pressure

☐ Urinary Tract Infection

☐ Measles (Regular or German)

☐ Gall Bladder Problem

☐ Rheumatic Fever

☐ Poor Sense of Smell

☐ Autoimmune Disorders

#### **G. PREVIOUS FERTILITY EVALUATION AND TREATMENT:**

Have you had:

☐ Hysterosalpingogram

☐ Cervical cauterization

or cervical laser surgery

☐ Fallopian tube surgery

☐ Endometrial biopsy

☐ Hormonal testing

☐ Urinary LH testing

☐ Chromosome studies

☐ Gonadotropin (Repronex, Gonal-F, Follistim, Pergonal...) for follicle stimulation, how many cycles?\_\_\_\_\_

☐ Previous attempts with Assisted Reproductive Technology, how many?

IVF\_\_\_\_\_

GIFT\_\_\_\_\_

ZIFT\_\_\_\_\_

Frozen embryo transfers\_\_\_\_\_

☐ Laparoscopy

☐ Hysteroscopy

☐ Dilatation and curettage

☐ Post coital examination

☐ Ultrasound monitoring of ovulation

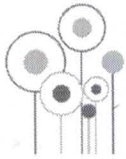
☐ Insemination with husband semen

☐ Insemination with donor semen

☐ Clomiphene cycles

#### **H. ETHNICITY**

- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Black/ African American
- ☐ Hispanic/ Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White



TEXAS CENTER FOR  
REPRODUCTIVE HEALTH

**FERTILITY QUESTIONNAIRE - MALE**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Wife's Name: \_\_\_\_\_

**A. GENERAL INFORMATION:**

1) How long have you been married? \_\_\_\_\_

2) How long have you been seeking a pregnancy? \_\_\_\_\_

3) Is this your first marriage? **Yes / No**

4) Do you have children from this marriage? **Yes / No**

How many children? \_\_\_\_\_ Adopted \_\_\_\_\_ Biological \_\_\_\_\_

5) Do you have children from previous marriage(s) or relationship? **Yes / No**

How many children? \_\_\_\_\_ Adopted \_\_\_\_\_ Biological \_\_\_\_\_

**B. Medical - Surgical:**

1) Have you ever had surgery? **Yes / No**

Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Place: \_\_\_\_\_

2) Have you recently lost or gained over 20 pounds? **Yes / No**

3) Do you exercise regularly? **Yes / No** If yes, how often and what type?

4) Do you follow any special dietary regimen? **Yes / No** If yes, what type?

5) Are you allergic to any medications? **Yes / No** If yes, please list:

7. Are you circumcised: **Yes / No**

If yes, when? \_\_\_\_\_

**Do you currently use or have you used:**

( ) Prescription drugs or medications

If yes, please list:

( ) Non-prescription drugs or medications

If yes, please list:

( ) Marijuana or other recreational drugs

( ) Tobacco products

What?

How much?

( ) Alcoholic beverages

What?

How much?

( ) Natural, herbal, multivitamin supplements?

What?

How often?

**Do you or have you ever had:**

( ) Anemia

( ) Appendicitis

( ) Arthritis

( ) Blood Product

Transfusions

( ) Breast Discharge

( ) Bronchitis

( ) Cancer

( ) Chlamydia

( ) Colitis

( ) Color Blindness

( ) Diabetes

( ) Dizziness

( ) Dyslipidemia -

abnormal levels of cholesterol lipids

( ) Epilepsy (Seizures)

( ) Ejaculation problems (i.e. retrograde ejaculation, premature or delayed ejaculation, no ejaculation)

( ) Gall Bladder Problems

( ) Gonorrhea

( ) Headache

( ) Heart Disease

( ) Hepatitis

( ) Herpes

( ) High Blood Pressure

( ) Immunizations

( ) Impotency (erectile dysfunction)

( ) Immunizations

( ) Intolerance to Heat or Cold

( ) Liver Problems

( ) Measles

( ) Mumps

( ) Excess Sweating

( ) Prostatitis

( ) Rheumatic Fever

( ) Thyroid Problems

( ) Testicular Pain or

Swelling

( ) Poor Sense of Smell

( ) Autoimmune Disorder

( ) Syphilis

( ) Urination Problems

( ) Urethritis

( ) Urinary Tract

Infection

( ) HIV

### **C. Previous Fertility Evaluation and Treatment:**

1. Have you had:

- ☐ Semen Analysis
- ☐ Sperm Antibody Assay
- ☐ Sperm DNA Testing
- ☐ Epididymal Aspiration
- ☐ Mucous Penetration Assay
- ☐ Hamster Egg Penetration Assay
- ☐ Testicular Biopsy
- ☐ Testicular Ultrasound
- ☐ Vasogram
- ☐ Hormonal testing
- ☐ Karyotyping (i.e. chromosomal studies)
- ☐ Vasectomy reversal
- ☐ Testicular Ultrasound

2. Have you previously received fertility medication? **Yes / No**

If yes, please list name and date \_\_\_\_\_

3. Have you had a hernia repair? **Yes / No**

If yes, please list name and date \_\_\_\_\_

4. Have you had a varicocele repair? **Yes / No**

If yes, please list name and date \_\_\_\_\_

5. Have you had undescended testicles? **Yes / No**

If yes, please list the date \_\_\_\_\_

6. Have you had testicular torsion? **Yes / No**

If yes, please list the date \_\_\_\_\_

7. Have you had testicular trauma or injury? **Yes / No**

If yes, please list the date \_\_\_\_\_

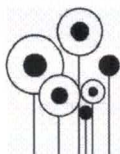
8. Do you wear **boxers** or **briefs**?

9. Do you spend any amount of time in a sauna or hot tub more than 2 or 3 times a year?

**Yes / No**      If yes, how often \_\_\_\_\_

### **D. Ethnicity:**

- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Black/ African American
- ☐ Hispanic/ Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White



TEXAS CENTER FOR  
REPRODUCTIVE HEALTH

## ART Request for Release of Medical Records

Please complete and fax to the physician from who you are requesting records. All medical records MUST be received at least 48 hours prior to your consultation.

**I hereby request that my medical records be released to:**

**Texas Center for Reproductive Health  
Baylor Medical Plaza – Barnett Tower  
3600 Gaston Avenue, Suite 504  
Dallas, Texas 75246  
Office: (214)821-2274 Fax: (214) 821-2373**

FROM: \_\_\_\_\_

Physician's Name

Address

City

State

ZIP

Fax #

Patient's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Husband's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Husband's signature is required if you are requesting male factor test results, such as Semen Analysis)

**HIV/AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

**Mental Health/Substance Abuse:** I consent to the release of information regarding my mental health and/or substance abuse treatment with the rest of my medical records.

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

### Records Requested:

\_\_\_ Cycle Flow Sheets

\_\_\_ All Embryology Records

\_\_\_ All Lab Reports

\_\_\_ All Imaging Reports & Films

\_\_\_ Other \_\_\_\_\_

\_\_\_ All Patient Care Notes

\_\_\_ All Calendars / Protocol Records

\_\_\_ Semen Analysis Reports

\_\_\_ All Operative Reports

This authorization is valid for 180 days. I understand that I may revoke this authorization at any time by sending written notice to the Texas Center for Reproductive Health. I further understand that my medical care is not conditional on the signing of this authorization and that the medical records may be re-disclosed for treatment purposes, payment purposes, or with proper authorization.

Revised 06/10/2015