



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 Number: \_\_\_\_\_

Are you a United States Citizen: Yes / No  
If no, list a permanent mailing address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_

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

SPOUSE INFORMATION

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

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

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

Are you a United States Citizen: Yes / No  
If no, list a permanent mailing address: \_\_\_\_\_

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

Texas Center for Reproductive Health reserves the right to modify the privacy practices outlines in the notice.  
\_\_\_\_\_, I have received a copy of the notice of privacy  
practices for Texas Center for Reproductive Health.

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

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

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 information to my insurance provider.



3600 GASTON AVE, STE 504  
DALLAS, TX 75246  
P: 214.821.2274  
F: 214.821.2373  
WWW.TXCRH.COM

## ART Request for Release of Medical Records

Please complete and fax to your physician upon receipt of this release form. All medical records MUST be received at least 48 hours prior to your consultation. We prefer that copies of the record be hand delivered, mailed, or sent by UPS or Fed Ex.

TO: \_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

\_\_\_\_\_  
Fax #

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  
(214)821-2274 office (214) 821-2373 fax

Patient's Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Date: \_\_\_\_\_

Husband's Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Date: \_\_\_\_\_

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

### Records Requested

- |   |   |
|---|---|
| <input type="checkbox"/> Cycle Flow Sheets                  | <input type="checkbox"/> All Patient Care Notes       |
| <input type="checkbox"/> All Embryology Records             | <input type="checkbox"/> All Patient Care Flow Charts |
| <input type="checkbox"/> All Lab Reports                    | <input type="checkbox"/> Semen Analysis Reports       |
| <input type="checkbox"/> All Imaging Reports & Actual Films | <input type="checkbox"/> All Operative Reports        |



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 family members or other persons whom we may inform about your general medical condition and your diagnosis:

\_\_\_\_\_

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

\_\_\_\_\_

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 – WIFE**

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? \_\_\_\_\_

Patient  
Name: \_\_\_\_\_

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:

Patient Name: \_\_\_\_\_

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? **Yes / No**

( ) Tobacco products? **Yes / No** What? How much?

( ) Alcoholic beverages? **Yes / No** What? How much?

7) Do you have or ever had:

- |   |                      |                                 |
|---|----------------------|---------------------------------|
| ( ) Anemia  | ( ) Allergies        | ( ) Auto Immune Disorders       |
| ( ) Appendicitis  | ( ) Arthritis        | ( ) Blood Product Transfusions  |
| ( ) Bronchitis  | ( ) Breast Cancer    | ( ) Cancer                      |
| ( ) Chlamydia   | ( ) Colitis          | ( ) Color Blindness             |
| ( ) Diabetes  | ( ) Dizziness        | ( ) Epilepsy (Seizures)         |
| ( ) Endometriosis   | ( ) Excess Sweating  | ( ) Excess Body or Facial Hair  |
| ( ) Gall Bladder  | ( ) Gonorrhea        | ( ) Heart Disease               |
| ( ) Hepatitis   | ( ) Herpes           | ( ) High Blood Pressure         |
| ( ) Hirsutism   | ( ) HIV              | ( ) Intolerance to Heat or Cold |
| ( ) Immunizations   | ( ) Liver Problems   | ( ) Measles (Regular or German) |
| ( ) Ovarian Cysts   | ( ) Pelvic Infection | ( ) Poor Sense of Smell         |
| ( ) Rheumatic Fever   | ( ) Thyroid Problems | ( ) Urinary Tract Infections    |
| ( ) Ulcers  | ( ) Vaginitis        | ( ) Visual Problems             |
| ( ) Dyslipidemia (i.e. abnormal levels of cholesterol/lipids) |                      |                                 |

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

Have you had:

- |   |  |
|---|--|
| ( ) Hysterosalpingogram   | ( ) Laparoscopy                        |
| ( ) Cervical cauterization<br>or cervical laser surgery   | ( ) Hysteroscopy                       |
| ( ) Fallopian tube surgery  | ( ) Dilatation and curettage           |
| ( ) Endometrial biopsy  | ( ) Post coital examination            |
| ( ) Hormonal testing  | ( ) Ultrasound monitoring of ovulation |
| ( ) Urinary LH testing  | ( ) Insemination with husband semen    |
| ( ) Chromosome studies  | ( ) Insemination with donor semen      |
| ( ) Gonadotropin (Repronex, Gonal-F, Follistim, Pergonal...) for follicle<br>stimulation, how many cycles? _____                        | ( ) Clomiphene cycles                  |
| ( ) Previous attempts with Assisted Reproductive Technology, how many?<br>IVF _____ GIFT _____ ZIFT _____ Frozen embryo transfers _____ |  |

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 - Husband

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 pregnancy? \_\_\_\_\_

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

4. Do you have children from this marriage? **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**

If yes, how much \_\_\_\_\_

3. Do you exercise regularly? **Yes / No**

If yes, how often and what type? \_\_\_\_\_

4. Are you allergic to any medications? **Yes / No**

If yes, please list: \_\_\_\_\_

5. Do you follow any dietary regimen? \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

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

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

a. Prescription drugs? **Yes / No**

If yes, please list: \_\_\_\_\_

b. Non-prescription drugs or medications? **Yes/ No**

If yes, please list: \_\_\_\_\_

c. Antibiotics? **Yes / No**

If yes, please list: \_\_\_\_\_

d. Marijuana or other recreational drugs? **Yes / No**

If yes, please list: \_\_\_\_\_

e. Tobacco products? **Yes / No**

What \_\_\_\_\_ How often \_\_\_\_\_

f. Alcoholic beverages? **Yes / No**

What \_\_\_\_\_ How often \_\_\_\_\_

g. Natural, herbal, multivitamin supplements: **Yes / No**

What \_\_\_\_\_ How often \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

- Anemia
- Appendicitis
- Arthritis
- Autoimmune Disorder
- Blood Product Transfusions
- Breast Discharge
- Bronchitis
- Cancer
- Chlamydia
- Colitis
- Color Blindness
- Diabetes
- Dizziness
- Dyslipidemia (i.e. abnormal levels of cholesterol lipids)
- Ejaculation problems (i.e. retrograde ejaculation, premature or delayed ejaculation, no ejaculation)
- Epilepsy (Seizures)
- Excess Sweating
- Impotency (erectile dysfunction)
- Gall Bladder Problems
- Gonorrhea
- Headache
- Heart Disease
- Hepatitis
- Herpes
- High Blood Pressure
- HIV
- Immunization
- Intolerance to Heat or Cold
- Liver Problem
- Measles
- Mumps
- Poor sense of smell
- Prostatitis
- Rheumatic Fever
- Syphilis
- Thyroid Problems
- Testicular Pain
- Testicular Swelling
- Urination Problems
- Urethritis
- Urinary Tract

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

1. Have you had:

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

Patient Name: \_\_\_\_\_

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