



7900 Fannin St. #4400  
Houston, Texas 77054  
Phone: (713) 512-7826  
Fax: (713) 512-7829

4724 Sweetwater Blvd. #105  
Sugar Land, Texas 77479  
Phone: (832) 553-5483  
Fax: (281) 491-2961

23920 Katy Frwy. #470  
Katy, Texas 77494  
Phone: (713) 578-3840  
Fax: (281) 347-2311

251 Medical Center Blvd. #230  
Webster, Texas 77598  
Phone: (713) 578-3880  
Fax: (281) 338-2982

**WELCOME TO FERTILITY SPECIALISTS OF HOUSTON!**

Please complete the following medical history forms and mail or fax them to us within two days of receipt. Returning your paperwork quickly can sometimes result in moving your appointment to an earlier date than currently scheduled. If you do not return this paperwork, your appointment may be rescheduled or cancelled.

Please send all these pages, except the last two pages of this packet (“Limited Patient Authorization for Disclosure of Protected Health Information”), back to our office. Send that form to your previous gynecologist or infertility physician. Make as many copies of this form as needed, and send directly to your other physicians. They will in turn send your records to us. **DO NOT RETURN THE “LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION” FORM TO OUR OFFICE. Complete it with the name of our physician that you will be seeing, as the “Entity Receiving Information”, and send it to your previous doctor(s).**

Please mail or fax your completed patient history form to the address below:

**Dr. Randall Dunn** or **Dr. Leah Schenk**  
“New Patient History”  
7900 Fannin #4400  
Houston, Texas 77054  
Fax: (713) 512-7829

**Dr. Subodh Chauhan**  
“New Patient History”  
4724 Sweetwater Blvd. #105  
Sugar Land, Texas 77479  
Fax: (281) 491-2961

Once we have received these documents, the office may contact you if they have additional questions. If indicated, we may be able to move-up your appointment date.

My name is \_\_\_\_\_.

My appointment date is \_\_\_\_\_, with Dr. \_\_\_\_\_.

**Please note failure to return medical history information may result in cancellation or rescheduling of your appointment.**

**Please circle the appropriate answer(s) for multiple choice questions**

Today's date \_\_\_\_\_ Appointment with Dr.: Dunn / Schenk / Chauhan  
 At: Medical Center Location / Sugar Land Location  
Katy Location / Webster Location

Date of appointment \_\_\_\_\_  
 Phone number during the day where you can be reached in the event we need to contact you prior to your appointment. ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Your Name \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Occupation \_\_\_\_\_

Husband/Partner Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Occupation \_\_\_\_\_

Married? Y/N How many years have you been married? \_\_\_\_\_

How tall are you? (feet/inches) \_\_\_\_\_ How much do you weigh? (pounds) \_\_\_\_\_

Who referred you to our doctor/clinic? \_\_\_\_\_

What is your reason for this visit? \_\_\_\_\_

If for pregnancy, how long have you been trying to get pregnant? \_\_\_\_\_

**OB History**

Have you ever been pregnant? Y / N If yes, please complete the information below.

Pregnancy	Ended by (Choose 1 from Key on right)	Pregnancy end Key		# of weeks at end of pregnancy	Date pregnancy ended	Delivery: vaginal or C-section
1		E	Elective abortion			
2		T	Tubal pregnancy			
3		M	Miscarriage			
4		P	Premature delivery			
5		F	Full term delivery			
6		O	Other (note below)			

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**Fertility History**

Previous evaluation: Have you ever been evaluated in the past for infertility? Yes / No  
If yes, were you diagnosed with (check all that apply): Endometriosis Immune disorder  
Male factor Ovulation disorder Tubal disorder Unexplained Unknown

Previous infertility treatment: Have you had any of the following infertility treatments? Y / N  
If yes, check all that apply. Dates/Results/If medication used, type and dose

- Timed intercourse without medications \_\_\_\_\_
- Timed intercourse **with** medications \_\_\_\_\_
- Insemination without medications \_\_\_\_\_
- Insemination **with** medications \_\_\_\_\_
- IVF without sperm injection \_\_\_\_\_
- IVF **with** sperm injection \_\_\_\_\_
- Frozen embryo transfer \_\_\_\_\_
- Donor egg \_\_\_\_\_
- Donor embryo \_\_\_\_\_
- Gestational carrier \_\_\_\_\_

**Menstrual/Ovarian History**

Age your period first started? \_\_\_\_\_

Cycle details (Check one box only)

- Periods stopped  Always regular  Sometimes irregular  Often irregular  Regular now, irregular before  Irregular now, regular before
- Other \_\_\_\_\_

How often do you have a period (e.g. Every 28-29 days)?  
Shortest number of days between periods: \_\_\_\_\_ Longest number of days between periods: \_\_\_\_\_

Have you done either of the following home testing? Yes / No  
If yes, check all that apply.  
Basal body temperature chart Results: \_\_\_\_\_  
Ovulation predictor kits Results: \_\_\_\_\_

Do you have any abnormal hair growth? Yes / No  
If yes, give location(s). \_\_\_\_\_

Do you have acne? Yes / No If yes, do you consider it to be... Mild Moderate Severe

Have you ever had hormone testing Yes / No If yes, list what kind, date and the results.  
\_\_\_\_\_  
\_\_\_\_\_

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**Pelvic/Uterine History**

Do you have pain with your period? Yes / No If yes, how many days: \_\_\_\_\_  
▪ Is it: Mild Moderate Severe ▪ Has it: Improved Worsened Stayed same  
▪ Does it cause you to miss work? Yes / No If yes, how many days: \_\_\_\_\_

Do you have pelvic pain other than with your period? Yes / No  
▪ If yes, is it: Rare Frequent Constant ▪ Severity: Mild Moderate Severe

Do you have pain with intercourse? Yes / No  
▪ If yes, on initial penetration? Yes / No ▪ On deep penetration? Yes / No

Have you ever had a pelvic infection? Yes / No

If yes, was it: Treated with:  
Chlamydia Unknown Outpatient antibiotics Inpatient IV antibiotics  
Gonorrhea Unknown Outpatient antibiotics Inpatient IV antibiotics  
Herpes \_\_\_\_\_  
Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous testing**

Have you had either of the following infertility testing? Yes / No

If yes, check all that apply.

Ovarian ultrasound monitoring Results: \_\_\_\_\_

HSG (uterine X-ray) \*include date Results: \_\_\_\_\_

**Gynecological Surgery History**

Have you ever had any gynecological surgery? Yes / No

If yes, check below:

	<u>Date</u>	<u>Reason and/or Outcome</u>
<input type="checkbox"/> Laparoscopy	_____	_____
<input type="checkbox"/> Hysteroscopy	_____	_____
<input type="checkbox"/> Laparotomy	_____	_____
<input type="checkbox"/> Cesarean section	_____	_____
<input type="checkbox"/> Cervical cryotherapy	_____	_____
<input type="checkbox"/> Cervical laser therapy	_____	_____
<input type="checkbox"/> LEEP	_____	_____
<input type="checkbox"/> D&C	_____	_____
<input type="checkbox"/> Tubes tied	_____	_____
<input type="checkbox"/> Other (note below)	_____	_____

(CONTINUE TO NEXT PAGE)

Have you ever had chicken pox? Yes / No

Have you been diagnosed with any significant medical problems? Yes / No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Gynecological History**

When was your last pap smear? \_\_\_\_\_ Was it normal? Yes / No

Have you ever had an abnormal pap smear? Yes / No Results? \_\_\_\_\_

Have you ever had a mammogram? Yes / No If yes, date? \_\_\_\_\_

Mammogram results? \_\_\_\_\_

**Patient's Medical History**

Do you take any medications, including over-the-counter medications, vitamins, or herbal treatments?  
Yes / No

If yes, list medication(s). \_\_\_\_\_  
\_\_\_\_\_

Have you ever used birth control? Yes / No

If yes, did you use: Began using Stopped using

Pills (brand) \_\_\_\_\_

Condoms \_\_\_\_\_

Depo-Provera \_\_\_\_\_

IUD (inserted/removed) \_\_\_\_\_

Tubes tied (date of surgery) \_\_\_\_\_

Other \_\_\_\_\_

Are you allergic to any medications, iodine, latex, or have any other allergies? Yes / No

Allergen	Reaction	Severity
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(CONTINUE TO NEXT PAGE)

Have you ever had any non-gynecologic surgeries? Yes / No

If yes, indicate below:

<u>Surgery</u>	<u>Date</u>	<u>Reason or Outcome</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? Yes / No If yes, how much and how often? \_\_\_\_\_

Do you smoke? Yes / No If yes, how much and how often? \_\_\_\_\_

If yes, at what age did you start smoking? \_\_\_\_\_

If you have stopped smoking, at what age did you quit? \_\_\_\_\_

Do you use smokeless tobacco? Yes / No

Do you use recreational drugs? Yes / No

If yes, what do you use, how much and how often? \_\_\_\_\_

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

How long have you been sexually active with your current partner? \_\_\_\_\_

How often do you have intercourse? \_\_\_\_\_

Does your family history include **any** medical conditions? Yes / No

<u>Medical Condition</u>	<u>Family Relationship</u>
<input type="checkbox"/> Chromosomal/genetic abnormalities	_____
<input type="checkbox"/> Birth defects	_____
<input type="checkbox"/> Other conditions: _____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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**Partner's History**

Has your male partner/husband fathered any children or pregnancies? Yes / No

If yes, how many children/pregnancies? \_\_\_\_\_ Date of most recent: \_\_\_\_\_

Does he have any of the following medical conditions?

<u>Condition</u>	<u>Date Diagnosed</u>	<u>Treatment(s)/Medication(s)</u>
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> Other _____	_____	_____
_____	_____	_____
_____	_____	_____

Does he take any medications, including over-the-counter medications, vitamins, or herbal treatments?

Yes / No

If yes, list medication(s). \_\_\_\_\_

Is he allergic to any medications? Yes / No

If yes, list medication(s). \_\_\_\_\_

Has he had previous semen analysis? Yes / No

If yes, give date(s) and result(s): \_\_\_\_\_

Has he been tested for male sperm antibodies? Yes / No

Does his family history include **any** medical conditions? Yes / No

<u>Medical Condition</u>	<u>Family Relationship</u>
<input type="checkbox"/> Chromosomal/genetic abnormalities	_____
<input type="checkbox"/> Birth defects	_____
<input type="checkbox"/> Other conditions: _____	_____
_____	_____
_____	_____

(CONTINUE TO NEXT PAGE)

Has he had any pelvic area surgeries? Yes / No

If yes, indicate below:

<u>Surgery</u>	<u>Date</u>	<u>Reason or Outcome</u>
<input type="checkbox"/> Vasectomy	_____	_____
<input type="checkbox"/> Varicocele repair	_____	_____
<input type="checkbox"/> Other: _____	_____	_____
_____	_____	_____
_____	_____	_____

Does he drink alcohol? Yes / No If yes, how much and how often? \_\_\_\_\_

Does he smoke? Yes / No If yes, how much and how often? \_\_\_\_\_

If yes, at what age did he start smoking? \_\_\_\_\_

If he has stopped smoking, at what age did he quit? \_\_\_\_\_

Does he use smokeless tobacco? Yes / No

Does he use recreational drugs? Yes / No

If yes, what does he use, how much and how often? \_\_\_\_\_

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

### **Genetic History**

What is your race? (i.e. Caucasian, African American, Asian, etc.) \_\_\_\_\_

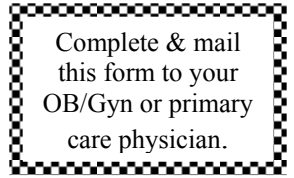
What is your ethnicity? (i.e. Irish, German, Italian, etc.) \_\_\_\_\_

What is your husband's race? \_\_\_\_\_

What is your husband's ethnicity? \_\_\_\_\_



**Fertility Specialists of Houston**  
 7900 Fannin, Suite 4400, Houston, Texas 77054  
 Ph: (713) 512-7826 Fax: (713) 512-7829



**Form 7.31**

**Limited Patient Authorization for Disclosure of Protected Health Information**

Please print all information. Form must be signed and dated.

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

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

**Purpose of request (who will be authorized to receive information)** - I authorize the practice to disclose or provide protected health information, about me, to: (please identify entity, person or persons who will receive the information):

**Entity Providing Information:**

Practice: \_\_\_\_\_  
 Provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Entity Receiving Information:**

Practice: \_\_\_\_\_  
 Provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above: (please provide a written description of the information to be disclosed):

- Entire patient record, including but not limited to: office notes; lab results; hospital, and other physician records; record of HIV and communicable disease testing; and record of mental health or substance abuse treatment.
- Office notes, labs only.
- Only send the following: \_\_\_\_\_

**Purpose of disclosure** (please check the purpose of the disclosure or check patient request):

- Patient transferring to our care  Continuation of obstetrical care
- Patient referred to us for treatment of: \_\_\_\_\_
- Other (please specify): \_\_\_\_\_
- Patient Request

**Expirations or termination of authorization:** authorization will expire one (1) year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any Ytime. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): \_\_\_\_\_

**Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

**Non-Conditioning statement:** The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

**Redisclosure:** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

\_\_\_\_\_  
 Patient signature *Copies of signed authorizations are available upon request.* \_\_\_\_\_ Date

## Explanation for Limited Patient Authorization

The Limited Patient Authorization will give our office the authority to provide access to your health information for the person you have listed on the form. The Limited Patient Authorization is limited to accessing your information and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to person's or entities that may be involved in your healthcare (i.e., family members or friends).

The following information will help to explain what information we will need and the purpose of specific sections of the form.

**Patient Name** - Print your name.

**Social Security Number and Date of Birth** - This information is needed for identity verification and will be maintained in a confidential manner at all times.

### Purpose of Request

**Entity Providing Information** - Print the name of our practice or, if you are requesting another healthcare provider to send information to us, the name of another healthcare provider. This simply identifies who will provide the information.

**Entity Receiving the Information** - Print the name and contact information of the person you want to receive or have access to your health information. If you are requesting another healthcare provider to send your health information to us, you would list the name and contact information for our practice.

**Description of Information to be Disclosed** - The type and amount of health information that we disclose is your choice. It can be all of your health information or it can be limited to specific information that you would list on the form.

**Purpose of Disclosure** - Regulations require that we identify the purpose for disclosing limited information (see choices on the form). You also have the right to keep the purpose to yourself by selecting "Patient Request".

**Expiration or Termination** - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information and verifying your wish to continue the authorization.

**Right to Revoke or Terminate** - You may revoke or terminate this authorization at anytime by contacting our Privacy Manager. Requests for revocation or termination must be made in writing.

**Non-Conditioning Statement** - This simply states that our practice does not place conditions for treatment on the use of this statement.

**Redisclosure Statement** - We cannot be responsible for what your Personal Representative does with your health information that we would provide under this authorization. The redisclosure statement simply informs you of this situation.

**Signature and Date** - We will need your signature and date of the signature to make the authorization effective.

**Copies** - We will provide you with a copy of this signed authorization upon request.

Please address any additional questions with our staff.