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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 forms within two days of receipt, and fax or mail them to the attention of "New Patient History". 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 page of this packet ("Authorization for Release of 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 directly to us. **DO NOT RETURN THE "AUTHORIZATION FOR RELEASE OF INFORMATION" FORM TO OUR OFFICE. CIRCLE THE NAME OF OUR PHYSICIAN THAT YOU WILL BE SEEING, AND SEND IT TO YOUR PREVIOUS DOCTOR(S).**

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)			

(CONTINUE TO NEXT PAGE)

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.

(CONTINUE TO NEXT PAGE)

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

<u>If yes, check below:</u>	<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? _____



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize

Doctor's Name

Street Address

City, State, ZIP

Mail this form to your OB/Gyn or primary care physician.

to furnish a copy of my medical records containing all lab work, gynecological operative reports, pap smears, mammograms and any infertility work-up and treatment for the past two years from the date of this authorization to:

Dr. Randall Dunn

Doctor's Name

7900 Fannin #4400

Street Address

Houston, Texas 77054

City, State, ZIP

Dr. Leah Schenk

Dr. Subodh Chauhan

Doctor's Name

4724 Sweetwater Blvd. #105

Street Address

Sugar Land, Texas 77479

City, State, ZIP

Purpose of Disclosure: Patient Request

I hereby release you, your physicians and employees from liability for following this authorization and request.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been in reliance on it. This consent will expire 1 year after the date of my signature unless otherwise specified.

The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations.

Re-disclosure – You have no control over the person(s) I have listed to receive my protected health information. Therefore, my 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 your practice.

Date

Patient's Signature

Date of Birth

Please Print Name

Patient's Street Address

City, State, ZIP

Copies of signed authorizations are available upon request