UT MEDICINE
HEALTH SCIENCE CENTER SAN ANTONIO

UT Medicine Fertility Center
Fertility Services

Medical Arts and Research Center
8300 Floyd Curl Drive, 5th Floor
San Antonio, TX 78229

210-450-9500

Welcome to the UT Medicine Fertility Center. The UT Medicine Fertility Center is a part of the UT Medicine Women's Health Center, the clinical center for the Department of Obstetrics and Gynecology of The University of Texas Health Science Center - San Antonio. At UT Medicine Fertility Center, we offer a comprehensive program of fertility-related services encompassing the latest advances in fertility research, state-of-the art technology, and sophisticated laboratory procedure. In addition, we offer an extensive education program for our patients, as well as the entire community, in order to foster a better understanding of disorders of fertility and reproductive endocrinology.

We offer our patients several options for counseling should they so desire. We can provide information regarding community support groups. We also work closely with a psychologist and a marriage and family therapist. Referrals can be arranged at your request.

The UT Medicine Fertility Center is staffed exclusively by reproductive endocrinologists, all of whom have full-time faculty appointments at The University of Texas Health Science Center at San Antonio. Our physicians include:

Robert S. Schenken, M.D.
Robert G. Brzyski, M.D., Ph.D.
Randal D. Robinson, M.D.

The UT Medicine Fertility Center is open from 7:30 am to 4:30 pm. Monday through Friday. In addition, we have limited morning office hours on Saturdays and most holidays. It is necessary to schedule all appointments in advance. All of our physicians, as part of their academic appointments at the medical school, are actively involved in research and teaching. Therefore, while your individual physician will always coordinate your care and will make all decisions concerning your treatment, you may see another physician for minor office visits. Surgical procedures will always be performed by your physician.

The center is located at the Medical Arts and Research Center, 8300 Floyd Curl Drive, San Antonio, TX 78229. Parking is available on the ground floor of the building. We can be contacted at (210) 450-9500.

WE MAKE LIVES BETTER
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Fertility Services

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8300 Floyd Curl Drive, 5th Floor
San Antonio, TX 78229

210-450-9500

Date:_____ Date & Time of Appointment:_____

Dear_____:

Enclosed is a welcome letter, a new patient information packet and an infertility history form.

Please fill out the new patient information packet, and the infertility history form as completely as possible and return it to us by mail or email as soon as possible.

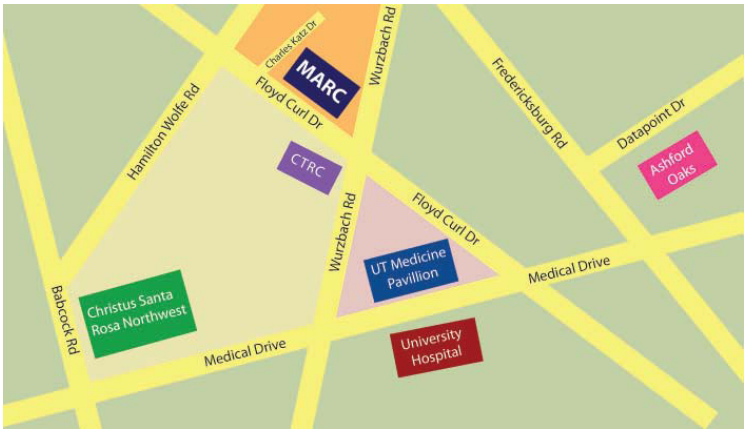
The day of your initial visit you will need to bring your medical records that pertain to your problem, and your insurance card for future billing of insurance if so desired.

Your assistance with this paperwork will help us to provide you with the quickest possible office visit.

Thank you for your attention to this matter. If you have any questions, please feel free to call.

We look forward to working with you.

LOCATION OF UT MEDICINE FERTILITY CENTER AT THE MARC



WE MAKE LIVES BETTER
UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER

PLEASE FILL IN AS COMPLETELY AS POSSIBLE

UT Medicine Fertility Center
Infertility History Form

Date of Visit:_____

Your Name:_____Age:_____Birthdate:_____

Address:_____

Home Telephone:_____Physician who referred you:_____

Your Occupation:_____

Your Employer:_____Telephone (work)_____

Spouse's Name (if applicable): _____

Spouse's Occupation:_____Spouse's Telephone (work)_____

Reason for your clinic visit:_____

_____

Describe as thoroughly as possible the background of your present problem. Include all symptoms, how long you have experienced them and indicate whether they have become worse, lessened or stayed the same in severity over time.

MENSTRUAL HISTORY:

At what age did you begin to menstruate?_____
What were the dates of your last two menstrual periods?_____
Have you ever gone more than 3 months without having a period? ☐Yes ☐No
If so, how long? (mos./yrs.)_____Approximate date(s) when this occurred:_____
_____
Are you normally ☐regular ☐irregular?
If irregular, please describe_____
What is the average length of your menstrual cycle? (Interval from 1st day of bleeding until day before bleeding of next cycle):_____
Has this changed since you started having periods? ☐Yes ☐No Explain: _____
_____
How many days do you bleed? _____
Is your flow ☐light ☐medium ☐heavy?
Does this vary?_____
If so, explain:_____
_____
Do you have pain during periods? ☐Yes ☐No (Describe):_____
Any pain between periods? ☐Yes ☐No (Describe):_____
_____
Do you bleed *between* periods? ☐Yes ☐No Describe frequency and amount of blood loss:_____
Frequency of intercourse:
_____times per week _____times per month_____N/A
Do you have any problems with intercourse? ☐Yes ☐No ☐N/A
Any changes in sex drive? ☐Yes ☐No ☐N/A
Do you bleed during or after intercourse? ☐Yes ☐No ☐N/A
Any pain during or after intercourse? ☐Yes ☐No ☐N/A
Do you have any vaginal discharge? ☐Yes ☐No ☐N/A
If yes, describe your discharge:_____
_____
(color, consistency, presence of odor, itching, etc.)
Have you had regular gynecologic exams? ☐Yes ☐No
Date of last exam _____
Date & result of last Pap smear_____
Have you had regular breast examinations? ☐Yes ☐No
Date of last exam_____
Date & findings of last abnormal exam_____
Date & findings of last mammogram_____
Have you ever had a milky discharge from one or both breasts? ☐Yes ☐No
If so, when_____
Have you had a history of: (If yes, please give date)
Chlamydia_____
Gonorrhea_____
Pelvic (tubal) infection_____

OBSTETRICAL HISTORY ☐ Not Applicable (continue on to next section)

Number	Date(s)	Months to Conceive?	Sex/Wt.	Vag./C-section)
Full Term_____ Deliveries (37 weeks or more)	_____	_____	_____	_____
	_____	_____	_____	_____
Premature_____ Deliveries (less than 37 weeks)	_____	_____	_____	_____
	_____	_____	_____	_____

	Number	Date(s)
Miscarriages	_____	_____
Abortions	_____	_____
Ectopic Pregnancies	_____	_____
Stillbirths	_____	_____
Newborn Deaths*	_____	_____

*(within 1 month of birth)

Were there any complications during or after your deliveries?
☐ Yes ☐ No
If yes, state which delivery and describe the complication(s):
_____
_____

Were any of your children born with birth defects?
☐ Yes ☐ No
If yes, state which delivery and describe the birth defect:
_____
_____

Dates of pregnancies with present husband/partner:_____
Number of living children from this marriage/relationship:_____
Did you have any pregnancies/children from a previous spouse/partner? ☐ Yes ☐ No
If yes, list the dates of pregnancies:_____
And living children:_____
If applicable, dates of pregnancies through artificial insemination (**donor** sperm only):
_____And living children:_____

CONTRACEPTION:

☐ Not Applicable
(continue on to next section)

Please check any of the following methods of contraception you are currently using and/or *have used in the past*. Fill in the dates of usage.

Method	Dates of Usage
Birth Control Pills ☐ Type:_____	_____
IUD ☐ Type:_____	_____
Diaphragm ☐	_____
Condom ☐	_____
Jellies/Foam ☐	_____
Withdrawal ☐	_____
Sterilization ☐ Male ☐ Female	_____

Other:_____

GENERAL MEDICAL HISTORY:

Do you have any allergies? (Specify):_____
_____

List current medications: State the name of medication, indication for its use, and how long you've taken it. Include both prescription and over-the-counter medication.

Medication	Starting	Through	Amount	Indications
1.				
2.				
3.				
4.				
5.				
6.				

List all *serious medical illnesses* with date(s). If hospitalized, where?
_____
_____
_____
_____
_____

List all *surgical procedures* you have had, the approximate date(s), durartion of your hospitalization(s) and name of hospital(s):
_____
_____
_____
_____

Your General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Childhood Illnesses: ☐ Routine (chicken pox, measles, mumps, etc.)
Unusual (Describe):_____
_____

Have you ever had a blood transfusion? ☐ Yes ☐ No
Approximate date:_____

Do you drink alcohol? Daily ☐ Weekly ☐ Monthly ☐ Never
Do you smoke cigarettes? ☐ Yes ☐ No
Number of packs per day:_____
If you smoked in the past and have quit, give the approximate dates of smoking:_____
_____

Drug usage in past year:
☐ Marijuana ☐ Cocaine ☐ Depressants ☐ Stimulants

State the substances and amount of use:_____

Have you had any difficulty or recent change in your habits of sleep, diet or exercise?
☐ Yes ☐ No If so, describe:_____
_____

FAMILY HISTORY

Check any of the following disorders which have occurred in your family. Next to each item state which family member (mother, maternal grandmother, etc.) had the problem. *This section does not refer to any problems that you yourself have had.*

☐ Cancer (specify) _____
☐ Diabetes
☐ Thyroid disorders
☐ Heart disease
☐ Hypertension
☐ Tuberculosis
☐ Seizures
☐ Obesity
☐ Psychiatric disorders
☐ Infertility
☐ Multiple Miscarriages
☐ Baby with birth defects/retardation
☐ Chromosome (genetic)
☐ Other: (specify) _____

REVIEW OF SYSTEMS

Check any of the following disorders you currently have or have a history of.

Central Nervous System — Physician's Notes
- ☐ Seizures
- ☐ Migraine headaches
- ☐ Other

EENT
- ☐ Eye disorders
- ☐ Double or blurry vision
- ☐ Problem with sense of smell
- ☐ Other

Physician's Notes

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Diagnosed with Rheumatic fever
- ☐ Heart valve disease
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Given prophylactic antibiotics
- ☐ Other

Respiratory

- ☐ Shortness of breath
- ☐ Asthma (Date of Last Attack)
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough producing blood
- ☐ Tuberculosis
- ☐ Other

Gastrointestinal

- ☐ Nausea/Vomiting
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Constipation
- ☐ Spastic Colon
- ☐ Other

Genito-urinary

- ☐ Bladder infections (cystitis)
- ☐ Kidney infection
- ☐ Vaginal infections
- ☐ Frequent urination
- ☐ Other

Musculo-Skeletal

- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematosus
- ☐ Other

Hematologic

- ☐ Blood clotting disorder
- ☐ Sickle cell anemia or trait
- ☐ Thrombophlebitis
- ☐ Other

Endocrine

Physician's Notes

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Excessive growth of hair on various parts of the body
- ☐ Hair loss
- ☐ Unexplained rash
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Excessive hunger/thirst
- ☐ Other

Skin

- ☐ Unexplained Rash
- ☐ Acne
- ☐ Skin Cancer
- ☐ Injuries
- ☐ Dermatitis
- ☐ Other

HUSBAND/PARTNER HISTORY

Birth date of husband/partner_____ Present Age_____

Duration of present marriage/relationship:_____

Has husband/partner initiated a pregnancy in a previous relationship? ☐ Yes ☐ No
If yes, please give dates and outcome of pregnancy._____

Has husband/partner had a previous relationship where pregnancy did not occur even though no contraception was used? ☐ Yes ☐ No
If yes, how long a period was involved?_____
_____

Any difficulty achieving or maintaining an erection? ☐ Yes ☐ No

Any difficulty with ejaculation (e.g., retrograde, premature)? ☐ Yes ☐ No

Any history of possible reproductive tract problem, (including dates) e.g., ☐ Prostatitis ☐ Epididymitis ☐ Orchitis ☐ Testicular tumor ☐ Injury to testes

Any history of transmissible disease? ☐ gonorrhea ☐ chlamydia ☐ Non-specific urethritis ☐ syphilis

Any history of reproductive tract surgery? ☐ Yes ☐ No
If yes, please give procedure and date_____
_____

MEDICAL HISTORY OF HUSBAND/PARTNER

Does husband/partner have any allergies? (specify):_____
_____

List current medications: State the name of medication, indication for its use, and how long medication has been taken. Include both prescription and over-the-counter mediation.

	Medication	Starting	Through	Amount	Indications
1.					
2.					
3.					
4.					
5.					
6.					

List all *surgical procedures*, approximate date, and hospital which husband/partner has undergone._____
_____
_____

List all significant *medical illnesses* requiring treatment. Include dates and name of physician/hospital which husband/partner has experienced.

_____
_____
_____
_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Childhood Illnesses: Routine (chicken pox, measles, mumps, etc.)
Unusual (Describe):_____
_____

Has husband/partner ever been in a serious accident? (describe)
_____
_____

Has husband/partner ever had a blood transfusion? ☐ Yes ☐ No
Approximate date:_____

Does husband/partner drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Does husband/partner smoke cigarettes? ☐ Yes ☐ No

Drug usage in past year: ☐ Marijuana ☐ Cocaine ☐ Depressants ☐ Stimulants

Any difficulty or recent change in your habits of sleep, diet, or exercise?_____
_____

Any recent illnesses or change in health? ☐ Yes ☐ No
If yes, please describe_____
_____

Any recent significant weight changes?_____
Present Weight_____Height_____

Has husband/partner been exposed to high temperatures (work, hot tubs, etc.)_____
☐ Radiation ☐ Chemicals ☐ Toxic substances

PAST INFERTILITY EVALUATION

Check all that apply:

	Date(s)	Results
Husband/partner semen analysis	_____	_____
Temperature charts	_____	_____
Postcoital tests	_____	_____
Endometrial biopsy	_____	_____
X-ray of tubes	_____	_____
Diagnostic laparoscopy	_____	_____
Hysteroscopy	_____	_____
Hormonal tests (which?)_____	_____	_____
Chromosomal studies (which)____	_____	_____

Medications taken:_____
_____

Please feel free to use the following section for any additional information you feel may be helpful in your fertility evaluation:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Purpose: The University of Texas Health Science Center at San Antonio (UT Health Science Center) and its faculty, students, residents, employees, and non-employees follow the privacy practices described in this Notice. The UT Health Science Center maintains your health information in records that are kept in a confidential manner, as required by law. The UT Health Science Center must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: The UT Health Science Center has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with radiologists or other consultants to make a diagnosis. UT Health Science Center may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, UT Health Science Center may use and disclose your health information to improve the quality of care, and for education and training purposes of UT Health Science Center students, residents, and faculty.

How Will the UT Health Science Center Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

- UT Health Science Center directories, which may include your name, general condition, religious affiliation, and your location in the UT Health Science Center. (*)
- Family members or close friends involved in your care or payment for treatment. (*)
- Disaster relief agency if you are involved in a disaster relief effort. (*)
- To inform you of treatment alternatives or benefits or services related to your health. (*)
- Fundraising activities by the UT Health Science Center. Such information will be limited to your name, address, phone number, and dates of treatment. If you do not want us to contact you for fundraising efforts, please contact the Office of Development at (210) 567-9219. (*)
- Appointment reminders.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.

- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state or local law.
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or other lawful request.
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation.
- Certain research projects, which requires a special approval process by the University.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

Your Authorization Is Required for Other Disclosures. Except as described above, we will not use or disclose your medical information, unless you allow the UT Health Science Center in writing to do so. For example, we will not use your photographs for presentations outside the UT Health Science Center without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

Alcohol and drug abuse information has special privacy protections. The UT Health Science Center will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or, as required by law.

You Have Rights Regarding Your Health Information. You have the following rights regarding your medical information, if requested on the form(s) provided by the UT Health Science Center:

- **Right to request restriction.** You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not.
- **Right to confidential communications.** You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- **Right to inspect and copy.** You have the right to review and obtain a copy of your medical or health record. Psychotherapy notes may not be inspected or copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the UT Health Science Center. The UT Health Science Center will comply with the outcome of the review.

- **Right to request amendment.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the UT Health Science Center. The UT Health Science Center is not required to accept the amendment.
- **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that have been made to persons or entities for disclosures unrelated to health care treatment, payment, or operations within the past six (6) years for paper health records, and for electronic health records you may request three (3) years, including disclosures for treatment, payment, or operations. After the first request, there may be a charge.
- **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our Web site, http://www.uthscsa.edu/hipaa/patientrights.asp. A more detailed Notice is also available at this Web site if you would like more information about these practices.

Requirements Regarding This Notice. The UT Health Science Center is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. The UT Health Science Center may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future. Each time you register at the UT Health Science Center for health services, you may receive a copy of the Notice in effect at the time.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with:

UT Health Science Center's Privacy Officer
Office of Regulatory Affairs & Compliance
7703 Floyd Curl Drive, Mail Code 7861
San Antonio, TX 78229-3900
(210) 567-5212

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
Washington, D.C. 20201

We will not penalize or retaliate against you in any way for making a complaint to the UT Health Science Center at San Antonio or to the Department of Health and Human Services.

Contact UT Health Science Center's Privacy Officer at (210) 567-5212 if:

- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

UT Medicine at San Antonio

NOTICE FOR REQUEST OF DISCLOSURE OF SOCIAL SECURITY NUMBER

(Patient Billing and Collections)

Disclosure of your Social Security Number (SSN) is required of you in order for UT Medicine San Antonio to bill and collect for patient services under Medicare or Medicaid. Federal law mandates a social security number is required to obtain benefits under Medicare and Medicaid (42 USC, Section 1320b-7(1)). For commercial insurance, there is no statute or authority that requires that you disclose your SSN. Failure to provide your SSN, however, may cause the insurance company to deny payment for lack of SSN. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information UT Medicine collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have UT Medicine correct information about you that is held by UT Medicine and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UT Medicine at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to UT Medicine HIPAA Compliance
By mail to: 6126 Wurzbach Road San Antonio TX 78238
By e-mail to: UPGPrivacy@UTHSCSA.edu
By fax to: (210) 257-1436
In person at: 6126 Wurzbach Road San Antonio TX 78238