

## **UT Medicine Fertility Center Fertility Services**

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Medical Arts and Research Center  
8300 Floyd Curl Drive, 5<sup>th</sup> 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:

Jennifer F. Knudtson, M.D.  
Randal D. Robinson, M.D.  
Robert S. Schenken, 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.

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## UT Medicine Fertility Center

### Fertility Services

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Medical Arts and Research Center  
8300 Floyd Curl Drive, 5<sup>th</sup> 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.

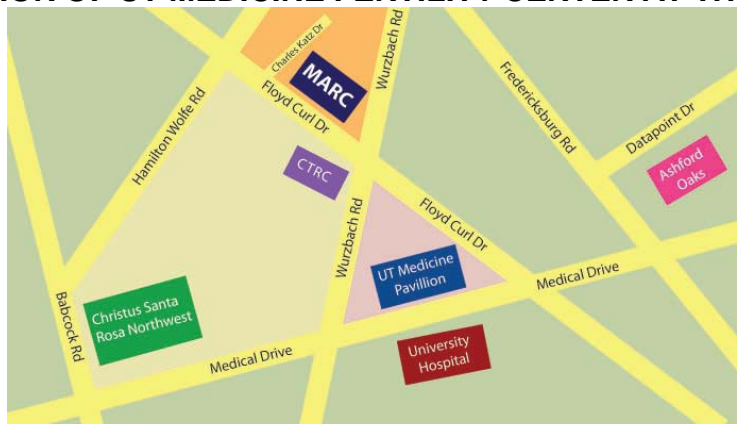
The day of your initial visit you will need to bring your medical records that pertain to your problem, and your insurance card for future billing of insurance if so desired.

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





**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): \_\_\_\_\_

(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):

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Were any of your children born with birth defects?

Yes  No

If yes, state which delivery and describe the birth defect:

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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.

<u>Method</u>	<u>Dates of Usage</u>
<input type="checkbox"/> Birth Control Pills Type: _____	_____
<input type="checkbox"/> IUD Type: _____	_____
<input type="checkbox"/> Diaphragm	_____
<input type="checkbox"/> Condom	_____
<input type="checkbox"/> Jellies/Foam	_____
<input type="checkbox"/> Withdrawal	_____
<input type="checkbox"/> Sterilization <input type="checkbox"/> Male <input type="checkbox"/> 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), duration 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?  Yes  No, If so,  Daily  Weekly  Monthly

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.*

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer (specify) _____ | <input type="checkbox"/> Baby with birth defects/retardation |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Seizures                            |
| <input type="checkbox"/> Thyroid disorders      | <input type="checkbox"/> Obesity                             |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Psychiatric disorders               |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Infertility                         |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Multiple Miscarriages               |
|   | <input type="checkbox"/> Chromosome (genetic)                |
|   | <input type="checkbox"/> Other: (specify) _____              |

## **REVIEW OF SYSTEMS**

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

### **Central Nervous System**

- Seizures  
 Migraine headaches  
 Other

### **Physician's Notes**

### **EENT**

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

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

- 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

Physician's Notes

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 medication.

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



## 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)

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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.

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