

MEDICAL QUESTIONNAIRE

Female Patient's Name: _____ Date: _____

The purpose of this questionnaire is to identify medical or genetic risk factors which may need further evaluation. Please circle/or write your answer and mail or fax back to us prior to your consultation. Feel free to expand on another piece of paper, if needed.

1. Reason for consultation: _____
If infertility, for how long have you been trying? _____ years _____ months
2. Past Medical History:
 - a) Please list all childhood illnesses (examples - chicken pox, measles, etc.):
Female Patient _____
Partner _____
 - b) Please list all chronic illnesses (examples - high blood pressure, diabetes, etc.):
Female Patient _____
Partner _____
 - c) Please list all medications and/or recreational drugs used:
Female Patient _____
Partner _____
 - d) List any allergies to medications:
Female Patient _____
Partner _____
 - e) List any surgery, hospitalization, and/or blood transfusions, the year it was done and any complications:
Female Patient _____
Partner _____
 - f) Do you smoke? Yes No How much? _____
Does your partner smoke? Yes No How much? _____
 - g) How much alcohol do you consume on a weekly basis?
Female Patient _____ Partner _____
 - h) Occupation:
Female Patient _____ Partner _____
3. GYN History
 - a) Age when you had your first menses (period) _____
 - b) How many days between the 1st day of one period and the 1st day of the next period? _____ days
_____ Days of bleeding _____
 - c) Amount of menstrual flow: __Heavy __Moderate __Light
 - d) Cramps: __Mild __Moderate __Severe
 - e) Do you have spotting before your periods? _____
 - f) Year of last pap smear: _____
 - g) Year of last mammogram: _____
4. Please list the types of contraception that you have used, when you started them and when you stopped them:

5. If you are married, please list the date of your marriage: _____
6. Sexual History
 - a) How many times per week do you have intercourse? _____ b) Do you have pain? _____

c) Do you use lubricants? _____ d) Erection or ejaculation problem? _____

MEDICAL HISTORY PAGE 2

7. Previous Pregnancy History:

<u>Miscarriages:</u>		<u>Livebirths:</u>			Complications
Year	Wks Preg.	Year	Sex	Birth Wt.	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

8. Review of Systems:

Please list any problems that you may have had with your heart, lungs, kidneys, liver, brain or hormone systems. Please list if you have had any abnormal hair growth on your chin, upper lip or sideburns:



9. Describe the ethnic background of you and your partner. Examples: Black, Italian, Jewish, Greek, Philippine, Southeast Asian.

Female patient _____ Partner _____

10. Do you or your partner have frequent exposure to:

Cats? Yes No Organic solvents? Yes No Pesticides? Yes No Heavy metal (lead, mercury)? Yes No

11. Has anyone in either of your families ever had any of the following disorders? Specify relationship to you (father, mother...).

	Female side	Partner's side
Down's Syndrome (Mongolism)	_____	_____
Mental Retardation	_____	_____
Neural Tube Defect, e.g., spina bifida/open spine.....	_____	_____
Cleft Lip/Palate	_____	_____
Hemophilia	_____	_____
Muscular Dystrophy	_____	_____
Cystic Fibrosis	_____	_____
Huntington Chorea.....	_____	_____
Thalassemia	_____	_____
Tay Sachs	_____	_____
Sickle Cell Disease or trait	_____	_____
Phenylketonuria	_____	_____
Cancer (who? and what kind?)	_____	_____
High blood pressure	_____	_____
Stroke	_____	_____
Diabetes	_____	_____
Heart attacks before age 50	_____	_____
Tuberculosis	_____	_____
Multiple miscarriages	_____	_____
Infertility	_____	_____
Other genetic or physical abnormalities _____	_____	_____

