

**MEDICAL QUESTIONNAIRE**

**Female Patient**

**Please answer the following questions to help with your consultation.**

**Please be as complete and accurate as possible.**

Name \_\_\_\_\_

Date \_\_\_\_\_

Age \_\_\_\_\_ Race \_\_\_\_\_

Reason(s) for your consultation: \_\_\_\_\_

What has been done to evaluate this problem before coming to this office? (If infertility, see separate section)

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

**I. PREVIOUS PREGNANCY HISTORY** (Please list the numbers of each below.).

a. Total number of pregnancies: \_\_\_\_\_ full term births: \_\_\_\_\_ premature births: \_\_\_\_\_  
miscarriages: \_\_\_\_\_ abortions: \_\_\_\_\_ living children: \_\_\_\_\_ adopted children: \_\_\_\_\_

b. List the dates, lengths, and outcomes of each of the above:

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

**II. GYN HISTORY**

a. Last menstrual period (first day of full flow): \_\_\_\_\_ Previous period: \_\_\_\_\_

b. Age when you had your first menses (period): \_\_\_\_\_

c. How long are your menstrual cycles (from day one to day one)? \_\_\_\_\_

How many days of bleeding do you have? \_\_\_\_\_

d. Do you have spotting before your menses? \_\_\_\_\_

e. Cramps: mild: \_\_\_\_\_ moderate: \_\_\_\_\_ severe: \_\_\_\_\_

f. Amount of menstrual flow: light: \_\_\_\_\_ moderate: \_\_\_\_\_ heavy: \_\_\_\_\_

g. Do you take any medications for cramps during your period? \_\_\_\_\_

If yes, what medication, amount taken, and how often?

\_\_\_\_\_

h. Do you need to take medication to start your periods? \_\_\_\_\_

i. Have you ever used an IUD? \_\_\_\_\_ If yes, list type used and when.

\_\_\_\_\_

j. Have you ever had an infection in your tubes or uterus? \_\_\_\_\_ If yes, please give details.

\_\_\_\_\_

k. Have you ever had a sexually transmitted disease? \_\_\_\_\_

Gonorrhea \_\_\_\_\_ Syphilis \_\_\_\_\_ Chlamydia \_\_\_\_\_ Herpes \_\_\_\_\_

If yes, when and how was it treated? \_\_\_\_\_

\_\_\_\_\_

1. When was your last Pap smear? \_\_\_\_\_ Normal or Abnormal? \_\_\_\_\_  
 Have you ever had an abnormal pap? \_\_\_\_\_ If yes, when and how was it treated? \_\_\_\_\_  
 \_\_\_\_\_

**III. MEDICAL HISTORY**

- a. Do you have any allergies to medications? If so, please list them and your allergic reaction.  
 \_\_\_\_\_  
 \_\_\_\_\_
- b. Are you currently taking any medications? If so, please list them, their doses and your reason for taking them. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- c. List any medical conditions that you have. \_\_\_\_\_  
 \_\_\_\_\_
- d. List any surgeries with the date you had them (including tonsils). \_\_\_\_\_  
 \_\_\_\_\_
- e. Family history: List family member with their history.

	Mother's Side	/	Father's Side
Cancer (type):	_____	/	_____
Diabetes:	_____	/	_____
Heart Disease:	_____	/	_____
High Blood Pressure:	_____	/	_____
Miscarriages:	_____	/	_____
Other:	_____	/	_____

**IV. SOCIAL HISTORY**

- a. Occupation: \_\_\_\_\_
- b. Do you smoke? If yes, how much? \_\_\_\_\_
- c. Do you drink alcohol? If yes, how much? \_\_\_\_\_
- d. Have you or do you use recreational drugs/steroids? If so, what, how much, how often and date last used. \_\_\_\_\_  
 \_\_\_\_\_

**V. INFERTILITY HISTORY**

*Have you had or used any of the following? When were they done and what were the results?*

- Basal body temperature charts: \_\_\_\_\_
- LH predictor kits (which ones): \_\_\_\_\_
- Hysterosalpingogram (HSG): \_\_\_\_\_
- Endometrial biopsy: \_\_\_\_\_

- Blood Work:
  - TSH (thyroid stimulating hormone): \_\_\_\_\_
  - Prolactin: \_\_\_\_\_
  - Estrogen: \_\_\_\_\_
  - FSH (follicle stimulating hormone): \_\_\_\_\_
  - LH (luteinizing hormone): \_\_\_\_\_
  - Sperm Antibodies: \_\_\_\_\_
  - Chlamydia Antibodies: \_\_\_\_\_
  - Testosterone: \_\_\_\_\_
  - DHEA Sulfate (dehydroepiandrosterone sulfate): \_\_\_\_\_
  - Insulin: \_\_\_\_\_
  - Other: \_\_\_\_\_

*Have you ever been treated with any of the following? When and what were the results?*

- Clomid/Serophene: \_\_\_\_\_
- Gonadotropins (Repronex, Follistim, Gonal F, Bravelle): \_\_\_\_\_
- HCG (Pregnyl, Profasi, Ovidrel): \_\_\_\_\_
- Progesterone Suppositories/capsules/injections: \_\_\_\_\_
- Synthroid/Levoxyl: \_\_\_\_\_
- Parlodel, Dostinex, Permax: \_\_\_\_\_
- Dexamethasone: \_\_\_\_\_

*Have you ever gone through IVF (In vitro fertilization)? When and what were the results?*

\_\_\_\_\_

\_\_\_\_\_

*Are there any other tests or procedures that have been done as part of your infertility evaluation or treatment?* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***I testify that I have answered all questions completely and accurately.***

***Signature:*** \_\_\_\_\_

**MEDICAL QUESTIONNAIRE**

**Male Patient**

**Please answer the following questions to help with your consultation.**

**Please be as complete and accurate as possible.**

Name \_\_\_\_\_

Date \_\_\_\_\_

Age \_\_\_\_\_ Race \_\_\_\_\_

Reason(s) for your consultation: \_\_\_\_\_

What has been done to evaluate this problem before coming to this office? (If infertility, see separate section)

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

**I. INFERTILITY HISTORY**

a. Have you ever fathered any pregnancies in this relationship? \_\_\_\_\_

List the dates and outcomes of the above:

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

b. Have you ever fathered any pregnancies in previous relationships? \_\_\_\_\_

List the dates and outcomes of the above:

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

c. Have you ever had a semen analysis? \_\_\_\_\_ If so when, where and what were the results?

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

d. Have you ever had an infection or surgery to your penis or testicles? \_\_\_\_\_

If so, please give details: \_\_\_\_\_

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

e. Have you ever had trauma to your penis or testicles that required medical attention? \_\_\_\_\_

If so, please give details: \_\_\_\_\_

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

f. Have you ever had a sexually transmitted disease? \_\_\_\_\_

Gonorrhea \_\_\_\_\_ Syphilis \_\_\_\_\_ Chlamydia \_\_\_\_\_ Herpes \_\_\_\_\_

If yes, when and how was it treated? \_\_\_\_\_

g. Do you have any trouble getting or keeping an erection? \_\_\_\_\_

How often and under what conditions? \_\_\_\_\_

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

h. Do you use hot tubs/saunas? \_\_\_\_\_ How often? \_\_\_\_\_

Are you exposed to heat in other ways? \_\_\_\_\_

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

i. Have you ever taken (list reason and results):

Clomid/Serophene: \_\_\_\_\_

Parlodel: \_\_\_\_\_

Proxeed: \_\_\_\_\_

Synthroid: \_\_\_\_\_

Other fertility medications: \_\_\_\_\_

**II. MEDICAL HISTORY**

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- b. Are you currently taking any medications? If so, please list them, their doses and your reason for taking them. \_\_\_\_\_
- c. List any medical conditions that you have. \_\_\_\_\_
- d. List any surgeries with the date you have had (including tonsils):  
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\_\_\_\_\_
- e. Family history: List family member with their history.

	Mother's Side	/	Father's Side
Cancer (type):	_____	/	_____
Diabetes:	_____	/	_____
Heart Disease:	_____	/	_____
High Blood Pressure:	_____	/	_____
Miscarriages:	_____	/	_____
Other:	_____	/	_____

**III. SOCIAL HISTORY**

- a. Occupation: \_\_\_\_\_
- b. Do you smoke? If yes, how much? \_\_\_\_\_
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- d. Have you or do you use recreational drugs/steroids? If so, what, how much, how often and date last used. \_\_\_\_\_

*I testify that I have answered all questions completely and accurately.*

**Signature:** \_\_\_\_\_