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_________ Syphillis_________ Chlamydia________ Herpes___________
If yes, when and how was it treated?____
____

l. 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 (dehydroepiandosterone 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

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 have had (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:	______	/	______

III. 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. ____________________

____

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

Signature: ____________________