Print Form

Medical History Form

Please fill in this form completely!

	Patient	Significant Other
Name:		
Address:		
City/State/Zip:		
Home Phone:		
Cell Phone:		
Date of birth:		
Social Security:		
E-mail Address:		

	Patient's Job	Significant Other's Job
Company:		
Address:		
City/State/Zip:		
Work Phone:		
Job Description:		

	Emergency Contact	Next of Kin
Name:		
Address:		
City/State/Zip:		
Phone:		

	Previous Fertility Doctor	Referring Person
Name:		
Address:		
City/State/Zip:		
Work Phone:		

How did you find us?

- ☐ Friend referred me — Who? _____
- ☐ Doctor referred me — Who? _____
- ☐ Yellow pages — What City/State? _____
- ☐ Internet — Where? _____
- ☐ Television — Where? _____
- ☐ Billboard — Where? _____
- ☐ Support group — Which one? _____
- ☐ Other — Where? _____

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Complete Name: _____ Date: _____ Age: _____

◯ Married ◯ Engaged ◯ Single ◯ Divorced ◯ Widowed

How can we help you? Please explain fully!

Gynecologic History

Pregnancies: ____ # Miscarriages: ____ # Abortions: ____ # Living Kids: ____ # Deceased Kids: ____

Date period started: _____ Date previous period started: _____

My periods come as close as every: _____ _____ and as far apart as every: _____ _____

I bleed as short as: _____ _____ or as long as every: _____ _____

_____ have bad cramps with my periods.

_____ have increase frequency of urination with my periods.

_____ have pain with sex.

_____ have loose stools or diarrhea with my periods.

Pap Smear History

My last pap smear was in _____ _____ I have _____ had an abnormal pap smear.

To treat my abnormal pap smear I have had: ☐ Nothing ☐ Freezing ☐ Cautery ☐ Leep ☐ Conization ☐ Colposcopy

Sexual History

How often do you have intercourse? _____ times per week.

Do you use lubricants with sex? ◯ Yes ◯ No If "yes", what type: _____

Husband takes "hot baths"? ◯ Yes ◯ No If "yes", how often: _____

Infertility Studies Performed: Applicable? ◯ Yes ◯ No

Test Name	Year Done	Results

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Wife's Review of Systems - Applicable? ◯ Yes ◯ No

Please list any of the conditions below that you have had:

Other:

Wife's Social History:

Do you smoke?	No	What type of work do you do?	
Do you drink alcohol?	No	If "yes" how many packs per day	
Do you currently use illicit drugs?	No	If "yes" how many drinks per week	
		If "yes" what type	

Wife's Medical History - Applicable? ◯ Yes ◯ No

Date	Type of medical disease

Wife's Surgical History - Applicable? ◯ Yes ◯ No

Date	Type of surgical procedure

Current Medications - Applicable? ◯ Yes ◯ No

Drug/Substance Allergies & Reactions- Applicable? ◯ Yes ◯ No

Medical History Form

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Spouse's Review of Systems: **Applicable?** ◯ Yes ◯ No

Please list any of the conditions below that you have had:

Other:

Spouse's Social History:

What type of work do you do?

Do you smoke? No

If "yes" how many packs per day

Do you drink alcohol? No

If "yes" how many drinks per week

Do you currently use illicit drugs? No

If "yes" what type

Spouse's Medical History - **Applicable?** ◯ Yes ◯ No

Date	Type of medical disease

Spouse's Surgical History - **Applicable?** ◯ Yes ◯ No

Date	Type of surgical procedure

Current Medications - Applicable? ◯ Yes ◯ No

Drug/Substance Allergies & Reactions - Applicable? ◯ Yes ◯ No