



**SEXUAL HISTORY:**

How many times do you have intercourse per week? \_\_\_\_\_ times per week ? None ? N/A

Have you used over-the-counter ovulation kits to time intercourse? ? Yes ? No

Do you have pain with intercourse? ? Yes ? No

Do you use lubricants (K-Y Jelly®. etc. (during intercourse? ? Yes – what types? \_\_\_\_\_ ? No

Have you had any of the following sexually transmitted diseases? ? Yes (check all that apply) ? No

? Chlamydia (date) \_\_\_\_\_ ? Genital warts/HPV (date) \_\_\_\_\_

? Gonorrhea (date) \_\_\_\_\_ ? HIV/AIDS (date) \_\_\_\_\_

? Herpes (date) \_\_\_\_\_ ? Hepatitis (date) \_\_\_\_\_

? Syphilis (date) \_\_\_\_\_ ? Other (date) \_\_\_\_\_

**MEDICAL HISTORY:**

Are you allergic to any foods (peanuts, eggs, etc.)? ? No ? Yes (Please list and describe reactions)

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List any medications you are currently taking, including over-the-counter medicine.

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Do you take any herbal medicines/vitamins or health food store supplements? ? No ? Yes (Please list)

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Do you have any medical problem(s)? ? No ? Yes (Please list type, dates, and treatments)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Did you have either of these childhood illnesses?

? Chickenpox (Varicella) ? German Measles (Rubella) ? Don't know

**SOCIAL HISTORY**

How many caffeinated beverages (coffee, tea, soda) do you drink per day? \_\_\_\_\_ ? None  
Do you smoke cigarettes? ? No ? Yes How many/day? \_\_\_\_ How many years? \_\_\_\_ Quit-when? \_\_\_\_  
Do you drink alcohol? ? No ? Yes: ? Beer-#/week \_\_\_\_ ? Wine-#/week \_\_\_\_ ? Liquor-#/week \_\_\_\_  
Do you use marijuana, cocaine, or any other similar drugs? ? No ? Yes (describe) \_\_\_\_\_  
Do you exercise? ? No ? Yes (describe) \_\_\_\_\_  
Are you aware of any radiation exposures other than X-rays? ? No ? Yes (describe) \_\_\_\_\_

**Physician Notes (for office use only)**  
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\_\_\_\_\_

**SURGICAL HISTORY:**

Have you had any surgeries? ? No ? Yes (List all surgeries in chronologic order)

<u>Year</u>	<u>Reason and Type of Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did you have any anesthesia problems? ? No ? Yes (Describe) \_\_\_\_\_

**PHYSICAL SYMPTOMS**

**General**

- ? Recent weight gain or loss
- ? Anorexia/Bulimia
- ? Lack of energy
- ? Fever/chills
- ? Other \_\_\_\_\_
- ? None

**Head, Eyes, Ears, Nose, and Throat**

- ? Dizziness ? Loss of sense of smell
- ? Headaches ? Chronic nasal congestion
- ? Blurred vision ? Ringing in ears
- ? Hearing loss/deafness
- ? Other \_\_\_\_\_
- ? None

**Respiratory**

- ? Shortness of breath
- ? Asthma ? Bronchitis
- ? Pneumonia
- ? Tuberculosis
- ? Bloody cough
- ? Other \_\_\_\_\_
- ? None

**Endocrine/Hormonal**

- ? Diabetes
- ? Thyroid gland problems
- ? Rapid weight gain/loss
- ? Excessive hunger/thirst
- ? Temperature intolerance  
hot flashes/ feeling cold
- ? Other \_\_\_\_\_
- ? None

**Neurological**

- ? Weakness/loss of balance
- ? Seizures/Epilepsy
- ? Headaches
- ? Migraine headaches
- ? Numbness
- ? Memory loss
- ? Other \_\_\_\_\_
- ? None

**Gastrointestinal**

- ? Nausea/vomiting
- ? Hepatitis
- ? Blood in stools
- ? Irritable Bowel Syndrome
- ? Change in bowel habits
- ? Colitis (ulcerative or Crohn's)
- ? Other \_\_\_\_\_
- ? None

**Genito-Urinary**

- ? Ulcers
- ? Diarrhea
- ? Constipation
- ? Bladder infections
- ? Kidney infections
- ? Frequent infections
- ? Leaking urine
- ? Blood in urine
- ? Herpes
- ? Other \_\_\_\_\_
- ? None

**Skin/Extremities**

- ? Unexplained rash/inflammation
- ? Acne
- ? Skin cancer
- ? Burn injury
- ? Moles changing in appearance
- ? Excess hair growth
- ? Other \_\_\_\_\_
- ? None

**Musculoskeletal**

- ? Unusual muscle weakness
- ? Decreased energy/stamina
- ? Rheumatoid arthritis
- ? Lupus Erythematosus
- ? Myasthenia gravis
- ? Other \_\_\_\_\_
- ? None

**Hematologic**

- ? Blood clotting disorder/blood clot
- ? Sickle Cell Anemia
- ? Thrombophlebitis
- ? Easy bruising
- ? Swollen glands/lymph nodes
- ? Blood transfusions (dates/reason) \_\_\_\_\_
- ? Other \_\_\_\_\_
- ? None

**Cardiovascular**

- ? Palpitations/skipped beats
- ? Chest pain
- ? Stroke
- ? High blood pressure
- ? Rheumatic fever
- ? Mitral valve prolapse (need antibiotics before dental procedures\_\_\_?)
- ? Heart attack
- ? Murmurs
- ? Other \_\_\_\_\_
- ? None

**Mental Health Problems**

- ? Depression
- ? Anxiety disorder
- ? Schizophrenia
- ? Other \_\_\_\_\_
- ? None

**Physician notes (for office use only)**

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**FAMILY HISTORY**

- |                      |                |      |
|----------------------|----------------|------|
|                      | <u>Living</u>  |      |
| Mother               | ? yes – age___ | ? No |
| Father               | ? yes – age___ | ? No |
| Brother(s)           | ? yes – age___ | ? No |
|                      | ? yes – age___ | ? No |
| Sister(s)            | ? yes – age___ | ? No |
|                      | ? yes – age___ | ? No |
| Maternal Grandmother | ? yes – age___ | ? No |
| Maternal Grandfather | ? yes – age___ | ? No |
| Paternal Grandmother | ? yes – age___ | ? No |
| Paternal Grandfather | ? yes – age___ | ? No |

Cause of Death/Age at Death

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**What is Your Ancestry?**

- |                         |                                   |                     |
|-------------------------|-----------------------------------|---------------------|
| ? African-American      | ? American-Indian/Native American | ? Caucasian         |
| ? Ashkenazi Jewish      | ? Asian-American                  | ? Eastern European  |
| ? Cajun/French Canadian | ? Hispanic/Caribbean              | ? Northern European |
| ? Southern European     | ? Other (specify) _____           |                     |

**Would you like to be screened for:**

- |                     |         |        |                      |         |        |
|---------------------|---------|--------|----------------------|---------|--------|
| ? Cystic Fibrosis   | ___ Yes | ___ No | ? Sickle Cell Anemia | ___ Yes | ___ No |
| ? Tay-Sachs Disease | ___ Yes | ___ No | ? Thalassemia        | ___ Yes | ___ No |

**Disorders in your family:****Relationship to You**

Colon Cancer	? Yes	_____	? No	? Don't Know
Other Cancer _____	? Yes	_____	? No	? Don't Know
Diabetes	? Yes	_____	? No	? Don't Know
Thyroid problems	? Yes	_____	? No	? Don't Know
Heart disease	? Yes	_____	? No	? Don't Know
Blood clots	? Yes	_____	? No	? Don't Know
Obesity	? Yes	_____	? No	? Don't Know
Psychiatric problems	? Yes	_____	? No	? Don't Know
Tuberculosis	? Yes	_____	? No	? Don't Know
Infertility	? Yes	_____	? No	? Don't Know
Birth defects	? Yes	_____	? No	? Don't Know
Cystic Fibrosis	? Yes	_____	? No	? Don't Know
Tay-Sachs disease	? Yes	_____	? No	? Don't Know
Canavan disease	? Yes	_____	? No	? Don't Know
Bloom syndrome	? Yes	_____	? No	? Don't Know
Gaucher disease	? Yes	_____	? No	? Don't Know
Niemann-Pick disease	? Yes	_____	? No	? Don't Know
Fanconi Anemia	? Yes	_____	? No	? Don't Know
Familial Dysautonomia	? Yes	_____	? No	? Don't Know
Muscular Dystrophy	? Yes	_____	? No	? Don't Know
Neurologic (brain/spine)	? Yes	_____	? No	? Don't Know
Neural Tube defects	? Yes	_____	? No	? Don't Know
Bone/Skeletal defects	? Yes	_____	? No	? Don't Know
Dwarfism	? Yes	_____	? No	? Don't Know
Developmental delay	? Yes	_____	? No	? Don't Know
Polycystic kidney disease	? Yes	_____	? No	? Don't Know
Heart defect from birth	? Yes	_____	? No	? Don't Know
Down syndrome	? Yes	_____	? No	? Don't Know
Other chromosome defects	? Yes	_____	? No	? Don't Know
Marfan syndrome	? Yes	_____	? No	? Don't Know
Hemophilia	? Yes	_____	? No	? Don't Know
Sickle Cell Anemia	? Yes	_____	? No	? Don't Know
Thalassemia	? Yes	_____	? No	? Don't Know
Galactosemia	? Yes	_____	? No	? Don't Know
Deafness/Blindness	? Yes	_____	? No	? Don't Know
Color blindness	? Yes	_____	? No	? Don't Know
Hemochromatosis	? Yes	_____	? No	? Don't Know
None of the above	? Other (specify)	_____		

**EMOTIONAL STATUS**

- ◆ On a scale of 1-10 (with 10 being the worst), estimate the level of stress you feel due to infertility and other pressures:\_\_\_\_\_
- ◆ Do you see a counselor? ? No ? Yes: For how long?\_\_\_\_\_ How often?\_\_\_\_\_

◆ List any anti-depressant/anti-anxiety medications you are currently taking: \_\_\_\_\_

◆ Describe any emotional, marital, or sexual problems caused by your infertility:

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

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I confirm that I have reviewed the information above.

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Physician notes (for office use only)**

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