FEMALE MEDICAL DATA

This questionnaire must be completed & received prior to your initial consultation with Dr. Silber.

Date: ____________

Name: ____ Date of Birth:_________________

Legal Last Name Legal First Name mm/dd/yyyy

Height: ______________________________ Weight:___________________

feet/inches pounds

How long have you been together with current partner_____?

How long have you been married ______________?

How long have you been trying to conceive _____?

How many pregnancies (including abortions) have you had? ____

	Year of outcome	End in Miscarriage?	End in Abortion?	End in Ectopic?	Infertility therapy required to conceive?	How long to conceive?	Baby born alive?	Is current partner the father?
1st pregnancy								
2nd pregnancy								
3rd pregnancy								
4th pregnancy								
5th pregnancy								

List dates and results of ultrasounds for infertility testing: _____________________________________

List dates and results of hysterosalpingograms: ____

List dates and results of laparoscopies or hysteroscopies: ____________________________________

List dates and results of hormone testing: ____

List all previous fertility treatment (i.e. IUIs, IVF, etc), where performed, and outcomes: _____________

____

Age when first period occurred_____ Date of last period:___________

How many days apart are your periods (i.e: 28?, 30? Irregular?)___________________________________

If irregular, how many periods per year?________

Do you have a history of blood clots or family history of blood clots (maternal or paternal)?_____

If yes, please explain: ____

What form of contraception do you use currently:

Pills (name)?___________ IUD (name)?_______________ Other?_____________ None_______________

ALLERGIES:

Are you allergic to any medications (including any tape, iodine, latex, etc) ___No ___Yes

If yes:

Medication name: _______________________ Type of Reaction: _________________________________

Medication name: _______________________ Type of Reaction: _________________________________

Are you allergic to any food? ____No. ____ Yes

If yes:

Food name: ____________________________ Type of Reaction: _________________________________

Food name: ____________________________ Type of Reaction: _________________________________

Please list any other allergies:____

MEDICAL DATA CONTINUED

Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:________

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SURGICAL HISTORY:

Have you had any previous surgeries? ______No ______Yes Anesthesia complications? ___No ___ Yes

If yes:

Date of operation Reason, type, & outcome of operation

____

____

CURRENT MEDICATIONS: (include all prescriptions,vitamins, supplements, over the counter medications)

Medication Name Dose Frequency

____

____

____

____

Are you on Oxygen or CPAP? _____No _____Yes

SOCIAL HISTORY:

Do you smoke cigars/cigarettes? ____No _____Yes If yes, how much per day/how many yrs_____________

Do you smoke marijuana? ____No _____Yes If yes, how often, how many yrs___________________

Do you use chewing tobacco? ____No _____Yes If yes, how often, how many yrs___________________

Do you use illicit drugs? ____No _____Yes If yes, what drug, how often, how much_____________

Do you drink alcohol? _____No ______Yes If yes, how much per day/how many yrs_____________

If you ever smoked in the past, when did you quit?____

FAMILY MEDICAL HISTORY:

(relationship to you)

Cancer ____No __Yes Type:____

High Blood Pressure ____No ___Yes ____

Heart Problems _____No ____Yes ____

Hepatitis _____No ____Yes ____

Clotting Problem _____No ____Yes ____

Bleeding Problem _____No ____Yes ____

Diabetes _____No ____Yes ____

Seizures/epilepsy ______No ____Yes ____

Asthma _____No ____Yes ____

High Cholesterol _____No ____Yes ____

MEDICAL DATA CONTINUED

Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:_______

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PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed with or are you currently having problems with any of the following?

Cardiac (heart/circulation) Please circle Y for yes or N for no

Congestive heart failure. Y/N Heart attack. Y/N Irregular heart beat. Y/N
High blood pressure. Y/N Pacemaker Y/N Chest pain Y/N
Heart valve problems. Y/N Palpitations. Y/N Leg swelling/edema Y/N
Heart murmur. Y/N Tingling/numbness in feet. Y/N Leg pain when walking Y/N

Pulmonary/ENT

Shortness of breath Y/N Asthma Y/N Recurrent/chronic cough Y/N
Wheezing Y/N Difficulty hearing Y/N Bloody cough Y/N
Emphysema/COPD Y/N Hoarseness Y/N Chronic sinus infection Y/N
Pulmonary embolism/Clot Y/N Recurrent bronchitis Y/N Chronic sore throat Y/N

Ocular

Decreased vision Y/N Double vision Y/N Macular degeneration Y/N
Diabetic retinopathy Y/N Blurry vision Y/N Cataracts Y/N

Digestive

Heart burn Y/N Acid reflux disease Y/N Cirrhosis Y/N
Ulcers Y/N Pancreatitis Y/N Crohn's/other colitis Y/N
Abdominal pain Y/N Diverticulitis Y/N Irritable bowel syndrome Y/N
Nausea/vomiting Y/N Loss of appetite Y/N Rectal bleeding Y/N
Weight Loss surgery Y/N If yes, what kind and when?________________________________

Breast

Mass/lump/abn_enlargement Y/N Aspiration/biopsy Y/N Fibrocystic breast disease Y/N

Kidney

Kidney failure Y/N Dialysis Y/N Kidney/ureteral stones Y/N

Endocrine (hormone)

Thyroid problems Y/N High/low blood sugar Y/N Diabetes Y/N
Excessive thirst Y/N Lupus Y/N Low testosterone (male) Y/N

Hematologic (blood)

Anemia Y/N Leukemia Y/N Clotting problem Y/N
Bleeding problem Y/N Other_________ Y/N

Infectious disease

Hepatitis A, B, or C Y/N Aids/HIV Y/N Tuberculosis Y/N
MRSA infection Y/N C-Diff. Y/N Other_____________________ Y/N

Musculoskeletal

Chronic back problems Y/N Chronic neck problems Y/N Fibromyalgia Y/N

Osteoarthritis Y/N	Rheumatoid arthritis Y/N	Osteoporosis/Osteopenia Y/N
Nontraumatic fractures Y/N	Joint pain Y/N. If yes, where?_______________	

Skin

Psoriasis Y/N	Eczema/rash Y/N	Changing moles Y/N

MEDICAL DATA CONTINUED

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Neurologic

Seizures Y/N	Stroke/TIA. Y/N	Headaches Y/N
Multiple sclerosis Y/N	Parkinson's. Y/N	Numbness Y/N
Loss of strength Y/N	Dizziness/Vertigo Y/N	Fainting/near fainting Y/N

Genitourinary (Male)

Prostatitis Y/N	BPH (prostate swelling) Y/N	Urinary frequency Y/N
Slowing of urinary system Y/N	Urinary tract infections Y/N	Sexual dysfunction Y/N

Genitourinary (Female)

Hot flashes Y/N	Vaginal dryness Y/N	Urinary frequency Y/N
Urinary tract infections Y/N	Sexual dysfunction Y/N	

Psychologic

Depression/Bipolar Y/N	Anxiety/nervousness Y/N	ADD/ADHD. Y/N

Cancer Y/N

Type: _______________________________________

First Diagnosed: ____

Treatment: ___________________________________

Do you have any other health conditions not listed? Y/N. ____