

ISLAND REPRODUCTIVE SERVICES
MEDICAL HISTORY FORM
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PATIENT CONTACT INFORMATION:

First Name _____ **Middle Initial** _____ **Last Name** _____

Age _____

Date of Birth ___ / ___ / ___ Occupation _____

Home Street Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Email address _____@_____

Are you married? Yes No Divorced Other _____

Partner's Name _____ **Middle Initial** _____ **Last Name** _____

Age _____

Date of Birth ___ / ___ / ___ Occupation _____

Same address as patient

Home Street Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Email address _____@_____

Who referred you?

Physician

Name: _____ Phone () _____

Address: _____

Former Patient / Friend / Other _____

Who is your OBGYN?

Name: _____ Phone () _____

Address: _____

Who is your primary care physician?

Name: _____ Phone () _____

Address: _____

Surgical History

Have you ever had surgery? NO YES - List below in order:

Year	Surgery and Reason and any Complications
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did you have any anesthesia problems? NO YES – Describe _____

Medical History

Do you have any medical problems? NO YES – Please List

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

Current Medications or Vitamins? _____

Do you have any allergies to medications or foods? NO YES If yes please explain _____

Have you ever had? Chicken Pox NO YES German measles (rubella) NO YES

Vaccinations

Chicken Pox (Varicella):	<input type="checkbox"/> NO	<input type="checkbox"/> YES year _____	<input type="checkbox"/> Unsure
Hepatitis B	<input type="checkbox"/> NO	<input type="checkbox"/> YES year _____	<input type="checkbox"/> Unsure
Tetanus	<input type="checkbox"/> NO	<input type="checkbox"/> YES year _____	<input type="checkbox"/> Unsure
Influenza (Flu)	<input type="checkbox"/> NO	<input type="checkbox"/> YES year _____	<input type="checkbox"/> Unsure
BCG (tuberculosis)	<input type="checkbox"/> NO	<input type="checkbox"/> YES year _____	<input type="checkbox"/> Unsure
MMR – Measles, mumps, rubella	<input type="checkbox"/> NO	<input type="checkbox"/> YES year _____	<input type="checkbox"/> Unsure

Breast Screening

Have you had a mammogram? NO YES – date ___ / ___ / _____ Result – Normal
 Abnormal: Please explain _____

Social History

- Caffeinated drinks per day? NO YES - how many/day? _____
- Do you smoke cigarettes? NO YES - how many/day? _____
- Do you drink alcohol? NO YES - how much/day? _____
- Other recreational drugs use? NO YES - Describe _____
- Do you exercise? NO YES - Describe _____

Ethnic Background: Caucasian Ashkenazi Jewish Asian Native American
 African American African Hispanic Other _____

Review of Systems

General:

- Weight loss or gain
- Anorexia - bulimia
- Lack of energy
- Other _____
- None

Head, Eyes, Ears Nose Throat:

- Headaches - blurry vision
- Dizziness
- Hearing loss - loss of smell
- Other _____
- None

Mental Health:

- Depression
- Anxiety Disorder
- Schizophrenia
- Other _____
- None

Respiratory:

- Shortness of breath - cough
- Asthma
- Pneumonia
- Tuberculosis
- Other _____
- None

Endocrine/Hormonal:

- Diabetes
- Thyroid problems
- Feeling Hot / Cold
- Excessive thirst / hunger
- Other _____
- None

Neurological:

- Weakness - loss of balance
- Seizures
- Numbness
- Memory loss
- Other _____
- None

Gastrointestinal:

- Nausea - Vomiting
- Diarrhea - Constipation
- Irritable bowel syndrome
- Crohn's - ulcerative colitis
- Other _____
- None

Genito-urinary:

- bladder / kidney infections
- Frequent urination - leaking urine
- Vaginal infection
- Blood in urine
- Other _____
- None

Skin/Extremities:

- Excess hair growth
- Acne
- Skin cancer
- Moles -change in appearance
- Other _____
- None

Breasts:

- Discharge
- Lumps Pain
- Abnormal mammogram
- Reduction - Augmentation
- Cancer
- Other _____
- None

Hematologic:

- DVT or pulmonary Embolism
- Sickle cell
- Swollen glands - lymph nodes
- Blood Transfusion(s)
- Blood Clotting Disorder - bruising
- Other _____
- None

Cardiovascular:

- Skipped heart beats
- Chest Pain
- Heart Attack
- Mitral valve prolapse
- Rheumatic fever
- Other _____
- None

Family History

Living

Cause of Death and Age

- | | | |
|----------------------|---|-------|
| Mother | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Father | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Brother(s) | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Sisters(s) | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Maternal Grandmother | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Maternal Grandfather | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Paternal Grandmother | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |
| Paternal Grandfather | <input type="checkbox"/> Yes – age ____ <input type="checkbox"/> NO | _____ |

Disorders in your family:	Relationship to You	
Breast Cancer	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Ovarian Cancer	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Colon Cancer	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Other Cancer _____	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Thyroids problems	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
DVT / Pulmonary Embolism	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Endometriosis / Infertility	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Early Menopause	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Heart Disease	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Any Birth defects	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Developmental delay	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Neural Tube Defects	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Sickle Cell	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Any genetic disease _____	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Other – Please specify _____		
<input type="checkbox"/> None of the above		

PRIOR FERTILITY TESTING AND TREATMENT

Have you ever had fertility testing or treatment before? YES NO

Prior Tests: (check those that apply)

Hysterosalpingogram (HSG) Date ___/___/___ Results _____

Semen Analysis Date ___/___/___ Results _____

FSH Date ___/___/___ Results _____

Prior Treatments	# Times	Date(s)	Outcome
Intrauterine Insemination (IUI)	_____	___/___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
Clomid and timed sex	_____	___/___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
Clomid with Insemination (IUI)	_____	___/___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
Injections with Insemination (IUI)	_____	___/___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant

In Vitro Fertilization (IVF)

1 Date _____	# eggs _____	# embryos transferred _____	# frozen _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
2 Date _____	# eggs _____	# embryos transferred _____	# frozen _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
3 Date _____	# eggs _____	# embryos transferred _____	# frozen _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
4 Date _____	# eggs _____	# embryos transferred _____	# frozen _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant

Frozen Embryo Cycles

1 Date _____	# Frozen Embryos transferred _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
2 Date _____	# Frozen Embryos transferred _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
3 Date _____	# Frozen Embryos transferred _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant
4 Date _____	# Frozen Embryos transferred _____	<input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant

PATIENT'S SIGNATURE _____ **DATE** _____

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PARTNER MEDICAL HISTORY

Complete with your partner if applicable: Partner's Sex: Male Female

Medical problems: _____

Check Any Medical Conditions that Apply to you: None
 Diabetes Mellitus Cancer High Blood Pressure Urinary Infections
 Multiple Sclerosis Prostatic Infections Neurological problem _____

Current Medications: _____

Allergies to medications or foods: _____

Do you consume caffeinated drinks? NO YES - How many/day? _____
Do you smoke cigarettes? NO YES - How many/day? _____
Do you drink alcohol? NO YES - How much/day? _____
Do you use other recreational drugs? NO YES - Describe _____

Ethnic Background: Caucasian Ashkenazi Jewish Asian Native American
 African American African Hispanic Other _____

Disorders in your Family:	Relationship to You	
Any Birth Defects	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Learning /Developmental Problems	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Down Syndrome	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Sickle Cell Anemia	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Cystic Fibrosis	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Neural Tube Defects	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
Any genetic disease – _____	<input type="checkbox"/> YES _____	<input type="checkbox"/> NO
<input type="checkbox"/> None of the above <input type="checkbox"/> Other – Please specify _____		

For Male partner (if applicable):

Have you been evaluated by a urologist? NO YES
Have you ever conceived a child? NO YES
Have you ever had a semen analysis? NO YES
Have you had problems with erection or ejaculation? NO YES
Have you had trauma / surgery of the penis / testicles? NO YES
Do you use hot tubs regularly? NO YES
Are you exposed to prolonged heat? NO YES
Have you had an infection of the penis, testicle, or scrotum? NO YES – Please Specify _____
Have you had exposure to radiation or chemotherapy? NO YES – Please Specify _____

PARTNER'S SIGNATURE _____ **DATE** _____

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE _____ **DATE** _____