Midwest Reproductive Center, PA

Dan L. Gehlbach, MD

Date: ___/___/______

Medical History Form - Infertility

Name:			Date of Birth: / /
Address:	City:	State:	Zip Code:
Telephone (Home): ( ) -	Work: ( ) -		Cell: ( ) -
Employer:			

Partner's Name:	Date of Birth: / /
Employer:	

Referring Physician:		Phone:	Fax:
Address:	City:	State:	Zip Code:
Primary Care Physician:		Phone:	Fax:
Address:	City:	State:	Zip Code:

Preferred Pharmacy:			
Address:	City:	State:	Zip Code:

Why are you seeing the doctor?

____

____

____

List all surgical procedures:

Type of Surgery	Date	Length of Stay	Name of Hospital/Surgeon

List all medications that you are currently taking:

Medication	Dose	Frequency (times per day)	Start Date

List all allergies (medication, food….)

Allergy	Reaction

Past Medical History (Please circle yes or no to each of the following…)

Have you been vaccinated against Hepatitis B?	**Yes**	**No**
Have you been screened for sickle cell trait?	**Yes**	**No**
Are you of Jewish or French Canadian ancestry?	**Yes**	**No**
If Yes, have you been screened for Tay-Sachs disease?	**Yes**	**No**
Is your partner of Jewish of French Canadian ancestry?	**Yes**	**No**
If Yes, has he been screened for Tay-Sachs disease?	**Yes**	**No**
Have you been screened for cystic fibrosis?	**Yes**	**No**
Has your partner been screened for cystic fibrosis?	**Yes**	**No**
Do any genetic disorders run in the family?	**Yes**	**No**
Do any genetic disorders run in your partner's family?	**Yes**	**No**
Have you ever had a problem with anesthesia?	**Yes**	**No**
Have you ever been given antibiotics before dental work?	**Yes**	**No**

Do you have a history of any of the following….

Asthma?	**Yes**	**No**
High blood pressure?	**Yes**	**No**
Heart valve disease?	**Yes**	**No**
High cholesterol?	**Yes**	**No**
Diabetes?	**Yes**	**No**
Blood transfusions?	**Yes**	**No**
Blood clotting disorders?	**Yes**	**No**

Anemia?	**Yes**	**No**
Thyroid problems?	**Yes**	**No**
Seizures?	**Yes**	**No**
Migraines?	**Yes**	**No**
Hepatitis?	**Yes**	**No**
Spastic colon/colitis?	**Yes**	**No**
Rheumatoid arthritis?	**Yes**	**No**
Lupus Erythematosus (SLE)?	**Yes**	**No**
Bladder/Kidney infection?	**Yes**	**No**
Sexually transmitted diseases? Type(s) _________________________________	**Yes**	**No**
Pelvic inflammatory disease?	**Yes**	**No**
Have you had any complications with previous pregnancies?	**Yes**	**No**
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	**Yes**	**No**

Social History

Occupation:_____________________________ **Ethnic Background:** ________________________________

Education: (circle) High School Grad 2 Yr College 4 Yr College

Post Graduate

Marital Status: Single Married (____yrs) Divorced Widowed Separated Domestic Partner (_____yrs)

Diet: Regular Vegetarian Diabetic Lo-Carb

Other:_____________________________

Hours Exercise per Week: 1-2 2-3 3-4 4-5 >5

Do you smoke? Yes No

If Yes, how much do you smoke? _____ **Have you smoked > 100 cig lifetime?** Yes No

Do you drink alcohol? Yes No

If Yes, how many drinks per week? 1-2 3-4 5 or more

Does your partner have children from a previous relationship? Yes No

Ages________________________

Partner's Occupation:

____

Partner's Medical Problems:

____

List all medications that your partner is currently taking:

Medication	Dose	Frequency (times per day)	Start Date

Family History:

Please check which family members have a history of each of the following disorders…

	Mother	Father	Brother	Sister	Son	Daughter	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Problems with anesthesia														
Cancer														
Thyroid problems														
Infertility														
Hormonal disorders														
High blood pressure														
Blood clotting disorders														
Diabetes														
Kidney Disease														
Heart Disease														
Birth defects														
Neurological disorders														
Other:														
Other:														

GYN History:

Age you started having periods _____ **# Days between Periods _____** (1st day of one period to 1st day of next period)

 # Days of Flow _____ **Are your periods regular? (circle)** Yes No

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Do you bleed or spot between periods? Yes No **Do you bleed/spot with intercourse?** Yes No

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Menstrual cramps: None Mild Moderate Severe **What pain medicine do you use?___________**

Do you have pelvic or abdominal pain? Yes No

If Yes, where is the pain located? ____________________ **What does it feel like? ____________________**

Most recent form of birth control used ____________________

Other forms of birth control used in the past____

How often do you have intercourse? ____________________

Do you use lubricants? Yes No

Is intercourse painful or difficult for you? Yes No

Date of Last Pap Smear: ____________________ **Results:** Normal Abnormal

Have you ever had an abnormal Pap Smear? Yes No **If Yes, Date:** ____________________

If Yes, what was the treatment? None Cone Biopsy Cryotherapy LEEP

Date of last mammogram: ____________________ **Results:** Normal Abnormal

What are your plans for conceiving a child?

As soon as possible In the future Never Unsure

What is the duration of your infertility? ____________________

How do you monitor ovulation?

Cervical mucous Basal Body Temp Ovulation kit Don't monitor

Other: Please Explain____

____

Have you used any of the following infertility treatments? If yes, please list date.

Clomid	Yes	No	Unsure	**Date:** ____________________
Femara (letrozole)	Yes	No	Unsure	**Date:** ____________________
Fertility shots	Yes	No	Unsure	**Date:** ____________________
Inseminations	Yes	No	Unsure	**Date:** ____________________
In Vitro Fertilization	Yes	No	Unsure	**Date:** ____________________
ICSI	Yes	No	Unsure	**Date:** ____________________
Frozen Embryo Transfers	Yes	No	Unsure	**Date:** ____________________
GIFT	Yes	No	Unsure	**Date:** ____________________

Have you had a hysterosalpingogram (HSG) done? Yes No

If Yes, Results? Normal Abnormal

Has a semen analysis been done? Yes No **If Yes, Results?** Normal Abnormal

<u>Obstetrical History</u>

In order, starting with your first pregnancy, please answer the following…

Date	**Outcome** (full term birth, preterm birth, miscarriage, ectopic, …)	**Complications**	**Time to Conceive**	**Infertility treatments used**	**Is your current partner the father?**

Midwest Reproductive Center, PA

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