Women for Women Medical Associates
102 I Centre Boulevard Marlton NJ 08053
Tel.: 856-267-5019 * Fax: 856-267-5025 * eFax: 856-294-5335
Email: contact@womenforwomenmedicalassociates.com

PATIENT MEDICAL INFORMATION

Patient Name: ________________________________ SSN: ___________________________

D.O.B.: ___________________

Years of current marriage/relationship: _____________

Number of marriages: __________________________

Duration of Fertility (months of trying w/o birth control): ________

Age of first menstrual period: _____________________

Number of days bleeding during menstrual period: ____________

Number of days between menstrual periods: ____________________
(From the first day of bleeding to the next first day of bleeding)

Do you have any symptoms prior to your menses? ___ Yes ___ No

Comment: ____

Do you have painful menses (Dysmenorrhea)? ___ Yes ___ No

Comment: ____

Is intercourse painful? ___ Yes ___ No

Comment: ____

Have you ever used an Intrauterine Device (IUD)? ___ Yes ___ No

Comment: ____

Do you have a history of pelvic infection (PID)? ___ Yes ___ No

Comment: ____

Did your mother take DES during her pregnancy? ___ Yes ___ No

Comment: ____

Do you have discharge from your breasts (galactorrhea)? ___ Yes ___ No

Comment: ____

Do you feel you experience excessive hair growth (hirsutism)? ___ Yes ___ No

Comment: ____

Pregnancy Data: Please list **all** pregnancies.

Preg #	Delivery Date/End	Outcome	Infertility Treatment?	# Months to Conceive	Sex	Conceive w/ Current Partner?	Comments (Weight, complications

Use additional paper if needed.

Previous Testing: List any previous fertility testing, with dates and results (if known).

_____ HSG (All testing required prior to IVF, from previous facility blood work onward)

____

____

____

____

Previous Treatment: List all previous fertility treatments, with dates and treatment types

____

____

____

____

Have you ever had a Hysterosalpinogram (Hysterogram, HSG)? Give dates and results

____

____

____

____

IVF History

Number of previous IVF/GIFT/ZIFT/TET cycles: _______ Please provide detailed information on these prior cycles (including dates, locations, medication dosages and outcomes of cycles etc.)

#	Date	Program Location	Medicatio n Dosage	Peak Estradiol	# of Eggs	# GIFT'd	# Fertilized	Fertilization Method	# Transferred	Pregn- ancy

Previous Surgery: Please list all surgeries (whether related to infertility or not)

Date	Location	Procedure	Findings	Surgeon	Asst.

Additional Information

Rubella Immunity... ___ Immune ___ Non-Immune

Pap... Date Tested _________ ___ Yes ___ No

Normal? ___Yes ___ No

Medical History

Do you have any medical problems unrelated to your infertility? Please check all that apply.

____ Diabetes

____ High Blood Pressure

____ Overactive/Underactive Thyroid

____ Epilepsy (Seizures)

____ Frequent Urinary Tract Infections

____ Kidney Disease

____ Asthma

____ Deep Vein Thrombosis

____ Anemia

____ Hepatitis

____ Rubella (German Measles)

____ Sexually Transmitted Diseases (Syphilis, Gonorrhea, Herpes Genital Warts)

____ Recreational Drug Use

Please Explain:

____

____

____

FAMILY HISTORY

Do any diseases run in your family? Do any of your relatives suffer from a major illness? Please indicate the nature of the illness and the relation to the family member.

____

____

Does anyone in your family have a history of breast cancer? ___ Yes ___ No

Comments: ____

Does anyone in your family have a history of ovarian cancer? ___ Yes ___ No

Comments: ____

Do you have any family history of birth defects? ___ Yes ___ No

Comments: ____

Do you have any family history of recurrent pregnancy loss? ___ Yes ___ No

comments: ____

Have you ever suffered from an eating disorder? ___ Yes ___ No

Do you exercise? How frequent and what type? ___ Yes ___ No

Comments: ____

Are you allergic to any medications? ___ Yes ___ No

Comments: ____

Are you allergic to anesthesia? ___ Yes ___ No

Comments: ____

Do you smoke cigarettes? How many cigarettes per day? ___ Yes ___ No

Comments: ____

Mycoplasma...Date tested ____________ ___ Pos ___ Neg Blood Type _________

Chlamydia...Date tested ______________ ___ Pos ___ Neg

Mammogram...Date tested ____________

Do you drink alcohol? How many per day? ___ Yes ___ No

Comments: ____

Do you take any medication regularly? Please list medications. ___ Yes ___ No

Comments: ____

Have you been exposed to any toxins? ___ Yes ___ No

Comments: ____

Do you use vaginal lubrication during intercourse? ___ Yes ___ No

Comments: ____

Did your mother have a hysterectomy? ___ Yes ___ No

Comments: ____

What was your mother's age at of menopause? ______

How many times a month do you have intercourse? ______

Have you ever used an ovulation predictor kit? ___ Yes ___ No

What days of your cycle does it indicate ovulation? ______

How many cups of coffee or caffeinated beverages do you drink daily ______

Comments: ____

Are you on any special diets or nutritional supplements? ___ Yes ___ No

Comments: ____

Do you take multivitamin supplements? ___ Yes ___ No

Comments: ____

Do you use herbal remedies? ___ Yes ___ No

Comments: ____

Do you take any over-the-counter medication? ___ Yes ___ No

Comments: ____

Genetic Screening

The following questions will help us determine if you are at increased risk of having a child with a genetic problem and if special screening is indicated.

Do you or anyone in your family have any of the following (please check all that apply):

	Disease Type	Relation		Disease Type	Relation
	Thalassemia			Muscular Dystrophy	
	Neural Tube Defect			Cystic Fibrosis	
	Down Syndrome			Huntington's Chorea	
	Tay Sachs			Mental Retardation	
	Hemophilia			Sickle Cell Anemia	
	Other Inherited Chromosonal/Genetic Abnormalities				

Comments:

____

____

____

Ethnic Origin

This will help identify risk factors for particular inherited diseases. Please check all that apply.

___ White Non-Hispanic ___ White Hispanic

___ Black Non-Hispanic ___ Black Hispanic

___ Asian or Pacific Islander Non Hispanic ___ Asian or Pacific Islander Hispanic

___ Native American (American Indian, including Aleut and Eskimo)

___ French Canadian ___ Jewish Background

___ Other (Explain: ____

Male Data

Name: ____
Last First Middle

Date of Birth: ____________ Age ______ SSN: ________________

Married: ___ Yes ___ No Number of Marriages: ________________

Occupation: ____________

Number of pregnancies conceived with current partner: ________________

Number of pregnancies conceived with a previous partner: ________________

Please give approximate pregnancy dates and outcomes with previous partner:

____

____

Urologist (if any): ____

Have you ever had a semen analysis (Sperm count) performed? ___ Yes ___ No

Please indicate date and reesults of most recent tests:

____

Date	Analysis Location	Count (Million/ml)	Mobility and Grade	Morphology

Do you have any medical problems unrelated to your fertility? Indicate the nature of the problem and treatment. Provide the name of the treating physician:

____

____

Have you had any surgeries? Indicate date and type of surgery:

____

____

Do you take any medication(s)? Indicate medication(s) and dosage:

____

____

____

Do you smoke cigarettes? ___ Yes ___ No

Comments: ____

Do you drink alcohol socially? ___ Yes ___ No

Comments: ____

Do you use any recreational drugs? ___ Yes ___ No

Comments: ____

Have you been exposed to any toxins? ___ Yes ___ No

Comments: ____

Do you have any difficulties with erection? ___ Yes ___ No

Comments: ____

Do you have any difficulty with ejaculation? ___ Yes ___ No

Comments: ____

Are your genitals exposed to excessive heat? ___ Yes ___ No

Comments: ____

Have you had any serious injuries to your genitals? ___ Yes ___ No

Comments: ____

Have you had any infections of your penis, testicles or prostate? ___ Yes ___ No

Comments: ____

Is there any history of birth defects in your family? ___ Yes ___ No

Comments: ____

Do you have any allergies to any medications? ___ Yes ___ No

Comments: ____

Are you on any special diets or nutritional supplements? ___ Yes ___ No

Comments: ____

Do you take any multivitamin supplements? ___ Yes ___ No

Comments: ____

Do you use herbal remedies? ___ Yes ___ No

Comments: ____

Do you take any over-the-counter medication(s)? ___ Yes ___ No

Comments: ____

Genetic Screening

The following questions will help us determine if you are at increased risk of having a child with a genetic problem and if special screening is indicated.

Do you or anyone in your family have any of the following (please check all that apply):

x	Disease Type	Relation	x	Disease Type	Relation
	Thalassemia			Muscular Dystrophy	
	Neural Tube Defect			Cystic Fibrosis	
	Down Syndrome			Huntington's Chorea	
	Tay Sachs			Mental Retardation	
	Hemophilia			Sickle Cell Anemia	
	Other Inherited Chromosonal/Genetic Abnormalities				

Comments:

____

____

____

____

Ethnic Origin

This will help identify risk factors for particular inherited diseases. Please check all that apply.

___ White Non-Hispanic

___ Black Non-Hispanic

___ Asian or Pacific Islander Non Hispanic

___ White Hispanic

___ Black Hispanic

___ Asian or Pacific Islander Hispanic

___ Native American (American Indian, including Aleut and Eskimo)

___ French Canadian

___ Jewish Background

___ Other (Explain: ____