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

Date: _____

Legal Name: _____
Last Name First Name Nickname

Date of Birth: _____ Height: _____ Weight:_____
mm/dd/yyyy feet/inches pounds

Home address _____ Social Sec.# _____

City, State, Zip _____

Home Phone (____)_____ Circle one: single engaged married

Cell Phone (____)_____

Work Phone (____)_____ Email address _____

Employer _____ Occupation _____

Female Ethnicity:

☐ White
☐ Hispanic
☐ Asian
☐ Refused
☐ Black or African American
☐ Native American or other Pacific Islander
☐ American Indian or Alaska Native

Do you have a partner? _____ How long married/ together? _____

Male Name: _____
Last Name First Name Date of Birth

How were you referred to us? _____

Have you ever been pregnant? If so, please list when and outcome of pregnancy:_____

_____

Age of first period: _____ 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: _____

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

_____

_____

List any other surgeries/hospitalizations you had in the past: _____

_____

List all medications or drugs you are currently taking, including over the counter medication. State how often and the reason for taking them: _____

_____

_____

What form of contraception do you use now or have used in the past:

Pills (name)?_____ IUD (name)?_____ Other?_____ None_____

Do you currently use tobacco products?_____ If yes, what kind and how much per day?_____

Do you drink alcoholic beverages?____ If yes, how much per day?_____

Do you use illicit drugs?_____ If Yes, please explain_____

Do you have any allergies to food, medications or other. Please list:_____

Please list any personal or family history of heart disease, cancer, diabetes, Hepatitis, sexually transmitted diseases, asthma, urinary problems, other:_____

_____

If you are a cancer patient, please include the following:

What is your diagnosis? Please be as specific as possible: _____

What was the date of your diagnosis? _____

Oncologist name AND phone number: _____

Have they started treatment? _____ If so, when and what kind: _____

What are their plans for treatment? (ex: chemo, radiation, surgery, etc):_____

When are they planning on beginning treatment? _____

Referred by _____ Phone (____)_____

Nearest relative _____ Phone (____)_____

Insurance Co. _____ Name of insured _____

Address _____ Group number _____

_____ Policy number _____

Ins. Co. Phone (____)_____ ID number_____

Signature _____ Date Signed _____