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

How long have you been together with current partner_____? How long have you been married _______?

How long have you been trying to conceive _____?

List all pregnancies including dates and their outcomes (please indicate current or previous partner):____

____

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: ______________________________

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: ____

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:____

____

Referred by	______________________	Phone (____)	______________________
Nearest relative	______________________	Phone (____)	______________________
Insurance Co.	______________________	Name of insured	______________________
Address	______________________	Group number	______________________
	______________________	Policy number	______________________
Ins. Co. Phone	(____)__________________	ID number	______________________
Signature	______________________	Date Signed	______________________