FEMALE MEDICAL DATA

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

Date: _____

Name: _____ Date of Birth:_____
Legal Last Name Legal First Name mm/dd/yyyy

Height: _____ Weight:_____
feet/inches pounds

How long have you been together with current partner_____?
How long have you been married _____?
How long have you been trying to conceive _____?
How many pregnancies (including abortions) have you had? _____

	Year of outcome	End in Miscarriage?	End in Abortion?	End in Ectopic?	Infertility therapy required to conceive?	How long to conceive?	Baby born alive?	Is current partner the father?
1st pregnancy								
2nd pregnancy								
3rd pregnancy								
4th pregnancy								
5th pregnancy								

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

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: _____

What form of contraception do you use currently:
Pills (name)?_____ IUD (name)?_____ Other?_____ None_____

ALLERGIES:

Are you allergic to any medications (including any tape, iodine, latex, etc) ☐No ☐Yes
If yes:
Medication name: _____ Type of Reaction: _____
Medication name: _____ Type of Reaction: _____

Are you allergic to any food? ☐No. ☐ Yes
If yes:
Food name: _____ Type of Reaction: _____
Food name: _____ Type of Reaction: _____

Please list any other allergies:_____

MEDICAL DATA CONTINUED

Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:_____

Name: _____ Date of Birth:_____
Legal Last Name Legal First Name mm/dd/yyyy

SURGICAL HISTORY:

Have you had any previous surgeries? ☐ No ☐ Yes Anesthesia complications? ☐ No ☐ Yes

If yes:

Date of operation Reason, type, & outcome of operation

_____

_____

CURRENT MEDICATIONS: (include all prescriptions, vitamins, supplements, over the counter medications)

Medication Name Dose Frequency

_____

_____

_____

_____

Are you on Oxygen or CPAP? ☐ No ☐ Yes

SOCIAL HISTORY:

Do you smoke cigars/cigarettes? ☐ No ☐ Yes If yes, how much per day/how many yrs_____

Do you smoke marijuana? ☐ No ☐ Yes If yes, how often, how many yrs_____

Do you use chewing tobacco? ☐ No ☐ Yes If yes, how often, how many yrs_____

Do you use illicit drugs? ☐ No ☐ Yes If yes, what drug, how often, how much_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much per day/how many yrs_____

If you ever smoked in the past, when did you quit?_____

FAMILY MEDICAL HISTORY:

(relationship to you)

Cancer ☐ No ☐ Yes Type:_____

High Blood Pressure ☐ No ☐ Yes _____

Heart Problems ☐ No ☐ Yes _____

Hepatitis ☐ No ☐ Yes _____

Clotting Problem ☐ No ☐ Yes _____

Bleeding Problem ☐ No ☐ Yes _____

Diabetes ☐ No ☐ Yes _____

Seizures/epilepsy ☐ No ☐ Yes _____

Asthma ☐ No ☐ Yes _____

High Cholesterol ☐ No ☐ Yes _____

MEDICAL DATA CONTINUED

Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:_____

Name: _____ Date of Birth:_____

Legal Last Name Legal First Name mm/dd/yyyy

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed with or are you currently having problems with any of the following?

Cardiac (heart/circulation) Please check No or YES.

Congestive heart failure. NO☐YES☐ Heart attack. NO☐YES☐ Irregular heartbeat. NO☐YES☐
High blood pressure. NO☐YES☐ Pacemaker NO☐YES☐ Chest pain NO☐YES☐
Heart valve problems. NO☐YES☐ Palpitations. NO☐YES☐ Leg swelling/edema NO☐YES☐
Heart murmur. NO☐YES☐ Tingling/numbness in feet. NO☐YES☐ Leg pain when walking NO☐YES☐

Pulmonary/ENT

Shortness of breath NO☐YES☐ Asthma NO☐YES☐ Recurrent/chronic cough NO☐YES☐
Wheezing NO☐YES☐ Difficulty hearing NO☐YES☐ Bloody cough NO☐YES☐
Emphysema/COPD NO☐YES☐ Hoarseness NO☐YES☐ Chronic sinus infection NO☐YES☐
Pulmonary embolism/Clot NO☐YES☐ Recurrent bronchitis NO☐YES☐ Chronic sore throat NO☐YES☐

Ocular

Decreased vision NO☐YES☐ Double vision NO☐YES☐ Macular degeneration NO☐YES☐
Diabetic retinopathy NO☐YES☐ Blurry vision NO☐YES☐ Cataracts NO☐YES☐

Digestive

Heart burn NO☐YES☐ Acid reflux disease NO☐YES☐ Cirrhosis NO☐YES☐
Ulcers NO☐YES☐ Pancreatitis NO☐YES☐ Crohn's/other colitis NO☐YES☐
Abdominal pain NO☐YES☐ Diverticulitis NO☐YES☐ Irritable bowel syndrome NO☐YES☐
Nausea/vomiting NO☐YES☐ Loss of appetite NO☐YES☐ Rectal bleeding NO☐YES☐
Weight Loss surgery NO YES If yes, what kind and when?_____

Breast

Mass/lump/abn_enlargement NO☐YES☐ Aspiration/biopsy NO☐YES☐ Fibrocystic breast disease NO☐YES☐

Kidney

Kidney failure NO☐YES☐ Dialysis NO☐YES☐ Kidney/ureteral stones NO☐YES☐

Endocrine (hormone)

Thyroid problems NO☐YES☐ High/low blood sugar NO☐YES☐ Diabetes NO☐YES☐
Excessive thirst NO☐YES☐ Lupus NO☐YES☐ Low testosterone (male)NO☐YES☐

Hematologic (blood)

Anemia NO☐YES☐ Leukemia NO☐YES☐ Clotting problem NO☐YES☐
Bleeding problem NO☐YES☐ Other_____ NO☐YES☐

Infectious disease

Hepatitis A, B, or C NO☐YES☐ Aids/HIV NO☐YES☐ Tuberculosis NO☐YES☐
MRSA infection NO☐YES☐ C-Diff. NO☐YES☐ Other_____ NO☐YES☐

Musculoskeletal

Chronic back problems NO☐YES☐ Chronic neck problems NO☐YES☐ Fibromyalgia NO☐YES☐

Osteoarthritis NO☐YES☐ Rheumatoid arthritis NO☐YES☐ Osteoporosis/Osteopenia NO☐YES☐
Nontraumatic fractures NO YES Joint pain NO YES. If yes, where?_____

Skin
Psoriasis NO☐YES☐ Eczema/rash NO☐YES☐ Changing moles NO☐YES☐

MEDICAL DATA CONTINUED
Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:_____

Name: _____ Date of Birth:_____
Legal Last Name Legal First Name mm/dd/yyyy

Neurologic
Seizures NO☐YES☐ Stroke/TIA. NO☐YES☐ Headaches NO☐YES☐
Multiple sclerosis NO☐YES☐ Parkinson's. NO☐YES☐ Numbness NO☐YES☐
Loss of strength NO☐YES☐ Dizziness/Vertigo NO☐YES☐ Fainting/near fainting NO☐YES☐

Genitourinary (Male)
Prostatitis NO☐YES☐ BPH (prostate swelling)NO☐YES☐ Urinary frequency NO☐YES☐
Slowing of urinary system NO☐YES☐ Urinary tract infections NO☐YES☐ Sexual dysfunction NO☐YES☐

Genitourinary (Female)
Hot flashes NO☐YES☐ Vaginal dryness NO☐YES☐ Urinary frequency NO☐YES☐
Urinary tract infections NO☐YES☐ Sexual dysfunction NO☐YES☐

Psychologic
Depression/Bipolar NO☐YES☐ Anxiety Nervousness NO☐YES☐
ADD/ADHD. NO☐YES☐

Cancer NO☐YES☐
Type: _____
First Diagnosed: _____
Treatment: _____

Do you have any other health conditions not listed? NO☐YES. _____