DURANGO REPRODUCTIVE
– MEDICAL HISTORY QUESTIONNAIRE –

Today's Date: _____

Patient Name (First, Middle, Last): _____
Nickname: _____ Do you use any other names? _____

Date of Birth: _____

Were you referred by another caregiver, if so who: _____

Referring caregiver Telephone #: _____

How long have you been trying to get pregnant? _____

What medical illness have you had, do you have? Pease circle: High blood pressure, Heart attack, Stroke, Thyroid disease, Diabetes, Blood clots, Bleeding problems, Blood or platelet transfusion, Cancer, Kidney disease, Liver Disease, Asthma, Lung Disease, Anxiety, Depression, Other_____

_____

Have you had any surgeries to your abdomen or pelvis including D&C?_____

What medications do you take?_____

Do you have any allergies, if yes to what, and what is your reaction to the medication?_____

_____

Do you use tobacco, if so how much? _____

Do you drink alcohol, if so how much? _____

Caffeine intake, how much: _____

Coffee: _____Tea: _____Sodas: _____ Chocolate: _____

Do you use any recreational drugs, if so, what type and how often ? _____

What medical illnesses have occurred in your family: parents, grandparents, aunts and uncles? Please circle illnesses and identify what relative had each illness. High blood pressure_____ Heart attack_____

Stroke_____ Thyroid disease_____ Diabetes_____ Blood clots_____

Bleeding problems_____ Transfusion_____ Cancer_____ Kidney disease_____

Liver disease_____ Asthma_____ Lung disease_____ Anxiety_____

Depression_____ Other_____

Is there any history of infertility or miscarriages in your family?_____

What is your ethnic background? _____

Do you have any gynecological problems?_____

Have you had any sexually transmitted diseases? If yes, please list_____

Have your Pap smears been normal? _____

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How old were you when your menses began? _____

What is the date of the start of your last menstrual flow?_____

How long does your flow usuallylast?_____

Do you have pain with your menstrual flow? _____

Is intercourse painful? _____

Have you ever been pregnant? _____If so when? _____

Have you delivered any children? _____ If so when? _____

Were any of your pregnancies conceived with another partner? _____

Have you had any abortions or miscarriages? If so when?_____

Have you had any previous evaluation for infertility? _____If so when? _____

Please tell us what testing has been done if you know. _____

_____

What is your Partner's Name (First, last)_____

What is his/her date of birth? _____

Does your partner have any medical illnesses, if so what? Please circle. High blood pressure, Heart attack, Stroke, Thyroid disease, Diabetes, Blood clots, Bleeding problems, Blood or platelet Transfusion, Cancer, Kidney disease, Liver disease, Asthma, Lung disease, Anxiety, Depression,

Other_____

Has your partner had any surgeries, if so what? _____

_____

Does your partner use any medications, If so what?_____

_____

Does your partner have any allergies; if so to what and what was the reaction? _____

Does your partner:

Use tobacco, if so how much? _____

Drink alcohol, if so how much? _____

Take caffeine, if so how much? _____

Use recreational drugs, if so, what type and how often? _____

Has your partner fathered any children/been pregnant? _____