Weshington Universay School of Medicine in St.Louis MEDICAL HISTORY QUESTIONNAIRE DEPARTMENT OF OBSTETRICS & GYNECOLOGY DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

Name: (Last, First, M.I.):					Date of Birth: (month/day/year)			<b>'s Date:</b> // <i>day/year</i> /	2
Who referred you to hear about us?	us/ho	w did you				·			
Reason for your visit	t today								
Are you trying to conce pregnant?	ive or b	ecome	□ Yes	□ No	If yes, how long wit ( <u>yrs/mos)</u>	hout protection	?		
				MENCERIA					
Date of last menstrual p	period			MENSTRUAL					
(month/day/year)	Jeniou				Age you started to hav	e periods			
Are your cycles regular	?		□ Yes	□ No	Number of cycles per y	ear?			
Longest duration (days)	•	•			Shortest duration (days	s) between peri	ods?		
On average, how many periods?	days be	etween			How long do your perio	ods last (days)?			
Do you have painful per	riods?		□ Yes	□ No	Do you have abnormal	bleeding?		□ Yes	□ No
				GYNECOLOGIC	AL HISTORY				
Have you used contract (birth control pills, contract condoms)			□ Yes	□ No					
Type of Contraception		Duration of	Use		·				
Have you been treated infection?	for a pe	lvic	□ Yes	□ No	Have you had Herpes?			□ Yes	□ No
Have you had Gonorrhe	ea?		□ Yes	□ No	Have you had HIV/ AII	DS??		□ Yes	□ No
Have you had Syphilis?			□ Yes	□ No	Have you had Bacteria	vaginosis (BV)	??	□ Yes	□ No
Have you had Chlamydi	ia?		□ Yes	□ No	Did your mother take DES?			□ Yes	□ No
Is there a history of phy	ysical ab	ouse?	□ Yes	□ No	Were you born premature?			□ Yes	□ No
Is there a history of sex	kual abu	se?	□ Yes	□ No	Birth weight <u>(pou</u>	nds/ounces)			
Did your mother require reproduction to conceiv		ed .	□ Yes	□ No	Date of last mammogra	am <u><i>(month/day</i></u>	<u>(year)</u>	( /	/ /) 🗆 None
Date of last PAP smear	(month	/day/year)			Was it normal?			□ Yes	□ No
Was it normal?			□ Yes	□ No	Do you have a history growth?	of abnormal hai	ir	□ Yes	□ No
History of abnormal PAP smear?			□ Yes	□ No	Do you have a history of PCOS (polycystic ovary syndrome)?		/stic	□ Yes	□ No
Have you had a cervica	l biopsy	?	□ Yes	□ No	Do you have a history of POE/POI		y?	□ Yes	□ No
What treatment for abn	ormal P	AP?			Do you have a history	of blocked tube	s?	□ Yes	□ No
Cryosurgery		LEEP	□ Cone	biopsy	Do you have a history	of tubal ligation	?	□ Yes	□ No
Have you had a history adhesions?	of pelvi	c	□ Yes	□ No	Do you have a history of a uterine abnormality?			□ Yes	□ No
Do you have a history o	of endor	netriosis?	□ Yes	□ No	Type of uterine abnor	mality?			
Do you have a history o	of uterin	e fibroids?	□ Yes	□ No					

Revised Oct 2012

Washington University Physicians Washington University School of Medicine in St. Jouis

## Weshington Universay School of Medicine in St.Louis MEDICAL HISTORY QUESTIONNAIRE DEPARTMENT OF OBSTETRICS & GYNECOLOGY DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

Prequency of Intercourse (per week)         Do you use lubricantis?         Pre No           DBSTETRICAL HISTORY           List date (nanth/yee/)         Outcome   Miscarriage   Ectopic   Vaginal delivery   Caesarian delivery   Abortion	SEXUAL HISTORY									
List date (manth/reat)         Outcome         Miscarriage         Ectopic         Vaginal delivery         Cesarian delivery         Abortion           /	Frequency of intercourse (per week)					Do you use	lubricant	s?	□ Yes □ No	
				OBST	ETRICA	L HISTOF	۲Y			
List date (month/yeah)       Outcome    Miscarriage    Ectopic    Vaginal delivery    Caesarian delivery    Abortion        /	List date <u>(month/year</u> )	Out	come 🗆	Miscarriage	🗆 Ectopi	c 🗆 Vaginal	delivery	Caesarian delivery	□ Abortion	
/	<i>/</i>	Con	ments:							
List date (manth/year)       Outcome   Miscarriage   Ectopic   Vaginal delivery   Caesarian delivery   Abortion	List date <u>(month/year</u> )	Out	come 🗆	Miscarriage	Ectopi	c 🗆 Vaginal	delivery	Caesarian delivery	□ Abortion	
	/	Con	nments:							
List date (month/year)       Outcome       Miscarriage       Ectopic       Vaginal delivery       Caesarian delivery       Abortion	List date <u>(month/year</u> )	Out	come 🗆	Miscarriage	🗆 Ectopi	c 🗆 Vaginal	delivery	□ Caesarian delivery	□ Abortion	
	/	Con	nments:							
List date (month/year)       Outcome       Miscarriage       Ectopic       Vaginal delivery       Caesarian delivery       Abortion	List date <u>(month/year</u> )	Out	come 🗆	Miscarriage	🗆 Ectopi	c 🗆 Vaginal	delivery	□ Caesarian delivery	□ Abortion	
/         Comments:           List date (month/year)         Outcome    Miscarriage    Ectopic    Vaginal delivery    Caesarian delivery    Abortion           /         Comments:           PRIOR INFERTILITY TREATMENTS (if applicable)           Cloniphene citrate            Yes    No         Number of cycles           Intrauterine insemin.            Yes    No         Number of cycles           FSH injectable meds            Yes    No         Number of cycles           IVF            Yes    No         Number of cycles           Metformin            Yes    No         Number of cycles           Other:            Yes    No         Number of cycles           Urine ovulation predicator kits            Yes    No         Dose           Urine ovulation predicator kits            Yes    No            Mormal    Abnormal           FSH blood test            Yes    No            Normal    Abnormal           Semen Analysis            Yes    No            Normal    Abnormal           Hysteroscopy            Yes    No            Normal    Abnormal           Hysteroscopy            Yes    No            Normal    Abnormal	/	Con	nments:							
List date (month/yeat)         Outcome         Miscarriage         Etopic         Vaginal delivery         Caesarian delivery         Abortion	List date <u>(month/year</u> )	Out	come 🗆	Miscarriage	🗆 Ectopi	c 🗆 Vaginal	delivery	□ Caesarian delivery	□ Abortion	
//       Comments:         PRIOR INFERTILITY TREATMENTS (if applicable)         Cloniphene citrate       Yes       No       Number of cycles       Intrauterine insemin.       Yes       No       No       No       No	/	Con	nments:							
PRIOR INFERTILITY TREATMENTS (if applicable)         Clomiphene citrate       Yes       No       Number of cycles         Intrauterine insemin.       Yes       No       Number of cycles         FSH injectable meds       Yes       No       Number of cycles         hCG injectable med.       Yes       No       Number of cycles         IVF       Yes       No       Number of cycles         Metformin       Yes       No       Dose         Other:       Yes       No       Dose         Urine ovulation predicator kits       Yes       No         FSH blood test       Yes       No       Normal       Abnormal         Semen Analysis       Yes       No       Normal       Abnormal         Hysteroscopy       Yes       No       Normal       Abnormal	List date <u>(month/year</u> )	Out	come 🗆	Miscarriage	🗆 Ectopi	c 🗆 Vaginal	delivery	Caesarian delivery	□ Abortion	
Clomiphene citrate       Yes       No       Number of cycles         Intrauterine insemin.       Yes       No       Number of cycles         FSH injectable meds       Yes       No       Number of cycles         hCG injectable med.       Yes       No       Number of cycles         IVF       Yes       No       Number of cycles         Metformin       Yes       No       Dose         Other:       Yes       No       Dose         Urine ovulation predicator kits         Yes       No       Normal       Abnormal         Semen Analysis       Yes       No       Normal       Abnormal         Hysteroscopy       Yes       No       Normal       Abnormal         Hysteroscopy       Yes       No       Normal       Abnormal	<i>/</i>	Con	nments:							
Clomiphene citrate       Yes       No       Number of cycles         Intrauterine insemin.       Yes       No       Number of cycles         FSH injectable meds       Yes       No       Number of cycles         hCG injectable med.       Yes       No       Number of cycles         IVF       Yes       No       Number of cycles         Metformin       Yes       No       Dose         Other:       Yes       No       Dose         Urine ovulation predicator kits         Yes       No       Normal       Abnormal         Semen Analysis       Yes       No       Normal       Abnormal         Hysteroscopy       Yes       No       Normal       Abnormal         Hysteroscopy       Yes       No       Normal       Abnormal		PF		NFERTILI <sup>®</sup>	TY TRE	TMENTS	(if apr	olicable)		
FM inducting including       I Yes       No       Number of cycles         FSH injectable meds       I Yes       No       Number of cycles         IVF       I Yes       No       Number of cycles         Metformin       I Yes       No       Dose         Other:       I Yes       No       Dose         Urine ovulation predicator kits       I Yes       No       Normal       Abnormal         FSH blood test       I Yes       No       I Normal       Abnormal         Semen Analysis       I Yes       No       I Normal       Abnormal         Hysteroscopy       I Yes       No       I Normal       Abnormal	Clomiphene citrate		1							
hCG injectable med.       I Yes       No       Number of cycles         IVF       I Yes       No       Number of cycles         Metformin       I Yes       No       Dose         Other:       I Yes       No       Dose         Urine ovulation predicator kits       I Yes       No       I Normal       Abnormal         FSH blood test       I Yes       No       I Normal       Abnormal         Semen Analysis       I Yes       No       I Normal       Abnormal         Hysterosalpingogram       I Yes       No       I Normal       Abnormal         Hysteroscopy       I Yes       No       I Normal       Abnormal	Intrauterine insemin.		□ Yes	□ No		Number of	cycles			
INCE INJECTABLE INCL.       Yes       No       Number of cycles       Image: Second Secon	FSH injectable meds		□ Yes	□ No		Number of	cycles			
Metformin       I Yes       No       Dose         Other:       I Yes       No       Dose         I Yes       No       Dose         PRIOR INFERTILITY EVALUATION (if applicable)         Urine ovulation predicator kits       I Yes       No       I Normal       Abnormal         Semen Analysis       I Yes       No       I Normal       Abnormal         Hysterosalpingogram       I Yes       No       I Normal       Abnormal         Laparoscopy       I Yes       No       I Normal       Abnormal         Hysteroscopy       I Yes       No       I Normal       Abnormal	hCG injectable med.		□ Yes	□ No		Number of	cycles			
Netronning       President in the second secon	IVF		□ Yes	□ No		Number of	cycles			
Image:			□ Yes □ No			Dose				
Urine ovulation predicator kitsYesNoNormalAbnormalFSH blood testYesNoNormalAbnormalSemen AnalysisYesNoNormalAbnormalHysterosalpingogramYesNoNormalAbnormalLaparoscopyYesNoNormalAbnormalHysteroscopyYesNoNormalAbnormal	Other:		□ Yes □ No			Dose				
Urine ovulation predicator kitsYesNoNormalAbnormalFSH blood testYesNoNormalAbnormalSemen AnalysisYesNoNormalAbnormalHysterosalpingogramYesNoNormalAbnormalLaparoscopyYesNoNormalAbnormalHysteroscopyYesNoNormalAbnormal		PF	RIOR IN	NFERTILI	TY EVA	LUATION	(if app	licable)		
Semen Analysis       I Yes       No       I Normal       Abnormal         Hysterosalpingogram       I Yes       No       I Normal       Abnormal         Laparoscopy       I Yes       No       I Normal       Abnormal         Hysteroscopy       I Yes       No       I Normal       Abnormal	Urine ovulation predicator kits		1							
Hysterosalpingogram       I Yes       No       I Normal       Abnormal         Laparoscopy       I Yes       No       I Normal       Abnormal         Hysteroscopy       I Yes       No       I Normal       Abnormal	FSH blood test		□ Yes	□ No		□ Normal	Abnc	ormal		
Laparoscopy     I Yes     No     I Normal     Abnormal       Hysteroscopy     I Yes     No     I Normal     Abnormal	Semen Analysis		□ Yes	□ No		□ Normal	🗆 Abno	ormal		
Hysteroscopy            Image: Society of the second	Hysterosalpingogram		□ Yes	□ No		□ Normal	□ Abno	ormal		
	Laparoscopy		□ Yes	□ No		□ Normal	Abno	ormal		
Comments:	Hysteroscopy		□ Yes	□ No		□ Normal	□ Abno	ormal		
	Comments:									

Washington University Physicians Washington University School of Medicine in St. Iouis

## MEDICAL HISTORY QUESTIONNAIRE

DEPARTMENT OF OBSTETRICS & GYNECOLOGY DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

## **CURRENT MEDICATIONS**

Inclu	ıde pre	scribed, over-the-c	ounter drugs, folic acid or vita	nmins,	herba	remedies or supplements, inhalers	;, etc.:			
Name	e of Med	lication	Strength/Dose		Frequ	iency Taken	Reason for Medication			
			CURRI	ENT A	LLER	GIES				
			Allergies to Mea	licatio	ns/Dru	g Sensitivities:				
	Name	of Medication			R	eaction to Medication				
			<b>4</b> 11			11-1				
			<b>Allergie</b> (Latex, adhesive ta							
		Allergy				Reaction				
			PAST M	EDIC	AL HJ	STORY				
Yes	No		Problem	Yes	No	Problem				
			Diabetes			Thyroid proble	ms			
		High	n Blood Pressure			Asthma or other lung/puln	other lung/pulmonary disorder			
		Lupus/	autoimmune disease			Arthritis	Arthritis			
		Bleeding or	blood clotting disorder			Problems with ane	olems with anesthesia			
		Blo	ood transfusion			Exposure to blood p	osure to blood products			
		Blood clots, deep	vein thrombosis or pulmonary embolus			Heart diseas	Heart disease			
		к	üdney disease			Infection				
Other	(explai	n)								
			PAS	ST SL	JRGE	RY				
Lis	t date	/ type of surgery /								
Rea	ison / j	ohysician / hospital								
			PAST HO	SPIT	ALIZ	ATIONS				
	List da	te / diagnosis / cian / hospital								

# Weshington University School of Medicine in St.Liouis MEDICAL HISTORY QUESTIONNAIRE DEPARTMENT OF OBSTETRICS & GYNECOLOGY DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

				9	<b>SOCIA</b>	L HIS	TORY				
(	Occupat	tion:									
Marita	al Statu	tatus Dingle Din					Separated Divorced Widowed				
Do yc	ou curre	ently consu	ime alcohol?	□ Yes Type:	Yes Type: Frequency/Amount:						
		noked at le your entir		□ Yes					🗆 No		
		smoke cig ays or not	arettes every at all?	Every Day		□ Som	e Days E	□ Not at All			
		igarettes o ay, on ave	lo (did) you erage?	□ 5 or fewer □ 26-35 (1½ pack)			(1/2 pack) E e than 36 (2 packs or mo	□ 16-25 (1 pack) pre)			
		tea, coffe beverages	e or other	□ Yes Type:			Frequency:		□ No		
Do yc	ou use r	marijuana	)	□ Yes			Frequency:	# of years:	🗆 No		
Do yc	ou use I	V drugs?		□ Yes Type:			Frequency:	# of years:	□ No		
				□ Sedentary (No exer	cise)						
	ou exerc	cico?		□ Mild exercise (i.e., c	limb sta	irs, wall	k 3 blocks, golf)				
DU yu				Occasional vigorous	exercise	0 min.)					
				□ Regular vigorous ex	ercise (i	0 140					
						.e., woi	k or recreation 4x/week	for 30 minutes)			
								for 30 minutes)			
Has a	anyboo	dy in you	r family had an		AMIL	Y HIS	TORY				
Has a Yes	anyboo No	dy in you Problen	-	F	AMIL	Y HIS	TORY	۰ ب	ho?		
			-	F y of the following? <i>(if</i>	AMIL'	Y HIS lease li	STORY st the family member	۰ ب	ho?		
Yes	No	Problem Cancer	-	F y of the following? <i>(if</i>	AMIL YES, pl Yes	Y HIS lease lii No	STORY st the family member Problem	۰ ب	ho?		
Yes	No	Problem Cancer High blo	n	F y of the following? <i>(if</i>	AMIL YES, pl Yes	Y HIS lease lin	<b>STORY</b> <i>est the family member</i> <b>Problem</b> Heart disease	۰ ب	ho?		
Yes	No	Problem Cancer High blo	n od pressure enopause	F y of the following? <i>(if</i>	AMIL YES, pl Yes	Y HIS lease li No	<b>STORY</b> <i>est the family member</i> <b>Problem</b> Heart disease Breast Cancer	۰ ب	ho?		
Yes 	<b>No</b>	Problem Cancer High blo Early me	n od pressure enopause Cancer	F y of the following? <i>(if</i>	YES, pl	Y HIS lease li	<b>STORY Set the family member Problem</b> Heart disease Breast Cancer Muscular dystrophy	۰ ب	ho?		
Yes	<b>No</b>	Problem Cancer High blo Early me Ovarian	n od pressure enopause Cancer prosis	F y of the following? <i>(if</i>	YES, pl	Y HIS Jease III	<b>STORY St the family member Problem</b> Heart disease Breast Cancer Muscular dystrophy Sickle-cell anemia	۰ ب	ho?		
Yes	<b>No</b>	Problem Cancer High blo Early me Ovarian Cystic fit Tay Sact	n od pressure enopause Cancer prosis	F y of the following? <i>(if</i>	AMIL YES, pl	Y HIS lease li No	<b>STORY St the family member Problem</b> Heart disease Breast Cancer Muscular dystrophy Sickle-cell anemia Mental retardation	۰ ب	ho?		
Yes	No	Problem Cancer High blo Early me Ovarian Cystic fit Tay Sact	n od pressure enopause Cancer prosis ns syndrome	F y of the following? <i>(if</i>	AMIL YES, pl	Y HIS lease li No	<b>STORY</b> <b>St the family member</b> <b>Problem</b> Heart disease Breast Cancer Muscular dystrophy Sickle-cell anemia Mental retardation Neurologic disease	۰ ب	ho?		
Yes	No	Problem Cancer High blo Early me Ovarian Cystic fik Tay Sach Down's s	n od pressure enopause Cancer prosis ns syndrome disease	F y of the following? <i>(if</i>	AMIL YES, pl 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Y HIS Jease II O	<b>STORY</b> <b>St the family member</b> <b>Problem</b> Heart disease Breast Cancer Muscular dystrophy Sickle-cell anemia Mental retardation Neurologic disease Deafness	۰ ب	ho?		
Yes	No	Problem Cancer High blo Early me Ovarian Cystic fit Tay Sach Down's s Thyroid	n od pressure enopause Cancer prosis ns syndrome disease	F y of the following? <i>(if</i>	AMIL <i>YES, pl</i> 	Y HIS Jease In O	FTORY         st the family member         Problem         Heart disease         Breast Cancer         Muscular dystrophy         Sickle-cell anemia         Mental retardation         Neurologic disease         Deafness         Blindness	۰ ب	ho?		
Yes	No	Problem Cancer High blo Early me Ovarian Cystic fit Tay Sach Down's s Thyroid	n od pressure inopause Cancer orosis is syndrome disease is problems	F y of the following? <i>(if</i>	AMIL         YES, pl         Q	Y HIS lease li No	FORY         St the family member         Problem         Heart disease         Breast Cancer         Muscular dystrophy         Sickle-cell anemia         Mental retardation         Neurologic disease         Deafness         Blindness         Recurrent miscarriage	۰ ب	ho?		
Yes	No	Problem Cancer High blo Early me Ovarian Cystic fit Tay Sach Down's s Thyroid Diabetes Bleeding	n od pressure inopause Cancer orosis is syndrome disease is problems	F y of the following? <i>(if</i>	YES, pl         Yes         0	Y HIS ease li No	FORY         st the family member         Problem         Heart disease         Breast Cancer         Muscular dystrophy         Sickle-cell anemia         Mental retardation         Neurologic disease         Deafness         Blindness         Recurrent miscarriage         Chromosome problem	۰ ب	ho?		
Yes	No	Problem Cancer High blo Early me Ovarian Cystic fil Tay Sach Down's s Thyroid Diabetes Bleeding Lung dis	n od pressure enopause Cancer prosis syndrome disease problems ease	F y of the following? <i>(if</i>	YES, pl         Yes         0	Y HIS ease li No C C C C C C C C C C C C C C C C C C	FTORY         st the family member         Problem         Heart disease         Breast Cancer         Muscular dystrophy         Sickle-cell anemia         Mental retardation         Neurologic disease         Deafness         Blindness         Recurrent miscarriage         Chromosome problem         PCOS	۰ ب	ho?		

## Washington University School of Medicine in St. Louis MEDICAL HISTORY QUESTIONNAIRE DEPARTMENT OF OBSTETRICS & GYNECOLOGY DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

-	5	ntly having any	Yes	ollowir No	-								
Weight Loss Weight Gain Fever Fatigue Autoimmune Hearing loss Sinus proble	1			No				1					1
Weight Gain Fever Fatigue Autoimmune Hearing loss Sinus proble	1				Problem Yes No Problem						Problem Yes		
Fever Fatigue Autoimmune Hearing loss Sinus proble				□ Breast pain						Abdominal pain			
Fatigue Autoimmune Hearing loss Sinus proble	e dis		ain 🗆 🗆 Muscle weakness							Constipation			
Autoimmune Hearing loss Sinus proble	e dis				Joint pain					Blood in urine			
Hearing loss Sinus proble	e dis				Anxiety					Pain with urination			
Sinus proble		sease			Depression					Urgency			
	5				Forgetfulness					Incontinence			
Dental probl	ems				Eye disorder				□ Rashes				
	lem	S			Vision change					Acne			
Palpitations					Contacts/Glasses					Excess body hair			
Mitral valve	pro	lapse			Seizure				□ Non-healing sores				
Chest pain					Headaches				□ Hot flashes				
Swelling of l	legs	/feet			Numbness					□ Night sweats			
Easy bruising	ıg				Shortness of brea	ath			Heat intolerance				
Bleed excess	sive	ly			Cough				Cold intolerance				
Enlarged lyn	nph	node			Wheezing					Hair loss			
Breast lump	)				Nausea/Vomiting				D     Thyroid proble				
Nipple disch	harg	e			Diarrhea				Excessive thirst				
				I	MMUNIZATIO	NS / GE	NETI	C HIS	TORY				
	]	Have you had a r	ubella tit					Have you had chicken pox?					
	]	Have you been so	creened f	or sickle	e cell disease?			Ha	ave you h	ad a chicken pox vac	ccine?		
	]	Have you been so	creened f	or cysti	c fibrosis?								
SIGNATU	UR	ES									DATE		
Patient													
Attending	Phy	/sician											
	• .1												
		your preferred pha	rmacy pr	ione nu	mper:								
Mail order pl	harı	macy information:											
					Please FAX your Attention of your		t 314-2						

😸 Washington University Physicians

## Washington University School of Medicine in St. Louis MEDICAL HISTORY QUESTIONNAIRE DEPARTMENT OF OBSTETRICS & GYNECOLOGY

DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

		ΡΑ	RTNER HIST	ORY	(IF APPLICABLE	)			
<b>Name:</b> (Last, First, M.I.):					Date of Birth: (month/day/year)		Age:		
Occupation:									
Marital Status	Single Married Partnered			<ul><li>Separated</li><li>Divorced</li><li>Widowed</li></ul>					
Number of pregnancies partner	s with current				Number of pregnancies partner(s)	s with previous			
					Age (s) of children, if a	ny:			
Do you currently consu	ume alcohol?	□ Yes Ty	De:	Frec	juency/Amount:			□ No	
Have you smoked at le cigarettes in your entir		□ Yes						🗆 No	
Do you now smoke cig day, some days or not		□ Every Da	у	□S	ome Days	□ Not at All			
How many cigarettes of smoke per day, on ave		□ 5 or few □ 26-35 (1			-15 (½ pack) Iore than 36 (2 packs or	□ 16-25 (1   more)	pack)		
Do you drink tea, coffe caffeinated beverages		🗆 Yes Ty	be:		Frequency:			□ No	
Do you use marijuana?	>	□ Yes		Freq	uency:	# of year	s:	🗆 No	
Do you use IV drugs?		□ Yes Type: Free			uency: # of years:			🗆 No	
Do you use anabolic st	eroids?	□ Yes Free		Freq	uency: # of years		s:	🗆 No	
Have you ever used ar	abolic steroids?	□ Yes Fr		Freq	quency: # of yea		s:	🗆 No	
Did your mother requir reproduction to concei		□ Yes □ No			Were you born premature?			□ Yes	□ No
					Birth weight <u>(pour</u>	nds/ounces)			
MEDICAL PROB	LEMS								
CURRENT MEDI	CATIONS				CURRENT ALLER	GIES (med	lication	a & non-r	nedication)
Name of Medication		Strength	/Dose		Name of Medication / A	Allergy		Reaction	
SEXUAL HISTOR	RY				1				
Do you have a history	? 🗆 Yes	□ No		Do you use lubricants?			□ Yes	□ No	
Do you have difficulty	with ejaculation?	□ Yes	□ No		Difficulty with intercour	se?		□ Yes	□ No
Have you had a semer	analysis?	□ Yes	□ No						
Results:									
			PAST	r su	RGERY				
List date / type of Reason / physician	surgery / / hospital								

Washington University Physicians Washington University School of Medicne in St. Iouis

## MEDICAL HISTORY QUESTIONNAIRE

DEPARTMENT OF OBSTETRICS & GYNECOLOGY DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

	PARTNER HISTORY – CONTINUED (IF APPLICABLE)											
			PAST	HOSE	PITAL	IZATIONS						
1	List date / diagnosis /											
	physician / hospital											
	FAMILY HISTORY											
Has	anyboo	dy in your family had	any of the following? (if	YES, pl	lease li	ist the family member):						
Yes	No	Problem	Who?	Yes	No	Problem W	'ho?					
		Cancer				Heart disease						
		High blood pressure				Breast Cancer						
		Early menopause				Muscular dystrophy						
		Ovarian Cancer				Sickle-cell anemia						
		Cystic fibrosis				Mental retardation						
		Tay Sachs				Neurologic disease						
		Down's syndrome				Deafness						
		Thyroid disease				Blindness						
		Diabetes				Recurrent miscarriage						
		Bleeding problems				Chromosome problem						
		Lung disease				PCOS						
		Obesity				Kidney disease						
		Thalassemia				Anesthetic problems						
		Blood Clotting Probler pulmonary embolus	ns/deep vein thrombosis/			Other						
SIG	NATU	IRES					DATE					
Part	ner											
Atte	nding I	Physician										