ISLAND REPRODUCTIVE SERVICES
MEDICAL HISTORY FORM
Eric Knochenhauer, MD
Michael Traub, MD

237 Richmond Valley Road
Staten Island, NY 10309
Phone (718) 948-6100
Fax (718)948-6114

3000 Hadley Road
South Plainfield NJ 07080
Phone (908) 412-9909
Fax (908) 412-9910

PATIENT CONTACT INFORMATION:

Age _____

First Name ______________ **Middle Initial** _____ **Last Name** ___________________

Date of Birth ___ / ___ / _____ Occupation ___________________

Home Street Address ____

City ____________________ State ______ Zip Code __________________

Home Phone (   ) _________ Work Phone (   ) _________ Cell Phone (   ) _________

Email address _________________________@__________________________

Are you married? [ ] Yes [ ] No [ ] Divorced [ ] Other ______________

Age _____

Partner's Name ______________ **Middle Initial** _____ **Last Name** _______________

Date of Birth ___ / ___ / _____ Occupation ___________________

[ ] Same address as patient

Home Street Address ____

City ____________________ State ______ Zip Code __________________

Home Phone (   ) _________ Work Phone (   ) _________ Cell Phone (   ) _________

Email address _________________________@__________________________

Who referred you?
[ ] Physician
Name: _____________________________ Phone (   ) _________
Address: ____
[ ] Former Patient / Friend / Other ___________________________________

Who is your OBGYN?
Name: _____________________________ Phone (   ) _______________
Address: ____

Who is your primary care physician?
Name: _____________________________ Phone (   ) _______________
Address: ____

FEMALE MEDICAL HISTORY

Reason For visit: [ ] Infertility [ ] Surgery [ ] Hormone Problem [ ] Other _________________

Please choose the number that most applies to you
1-No stress 2-Some stress 3-Moderate stress 4-Heavily stressful 5-Extremely stressful

How much stress about infertility do you feel that you place upon yourself?
How much stress about infertility do you feel is placed upon you by friends, family members, or parents?
How much stress about infertility do you feel that is placed upon you by your partner?
How much stress do you experience on a daily basis in your work and/or home life, unrelated to infertility?

What question(s) do you want answered at this visit? ____
____
How many months have you been trying to become pregnant (if applicable)? __________________

On a scale of 1-10, estimate the level of stress you feel due to infertility or other concerns? ________

Pregnancy Summary:

Total Number of **ALL** Pregnancies ______
Number of Full term Deliveries ______
Number of pre-term deliveries (<37 weeks) ______

Number of Miscarriages (<20 weeks) ______
Number of Elective Terminations ______
Number of ectopic/Tubal pregnancies ______

Year	**Any fertility treatment to conceive?**	**Delivery Type (vaginal/cesarean/ D&C) and Complications**	**Current Partner?**	**Birth Defects?**
1. ________	___________________	______________________________	[ ] Y [ ] N	[ ] Y [ ] N
2. ________	___________________	______________________________	[ ] Y [ ] N	[ ] Y [ ] N
3. ________	___________________	______________________________	[ ] Y [ ] N	[ ] Y [ ] N
4. ________	___________________	______________________________	[ ] Y [ ] N	[ ] Y [ ] N
5. ________	___________________	______________________________	[ ] Y [ ] N	[ ] Y [ ] N

Menstrual History

Menstrual Cycle Pattern: [ ] Regular [ ] Irregular [ ] No periods [ ] Heavy [ ] Light [ ] Painful

Number of bleeding days each cycle ____ days Number of days between each cycle ____ days
Dates of 1st day of your last 2 menstrual cycles ___ / ___ / _____ ; ___ / ___ / _____

Age when you had: First Period ____ years old Breast development ____ years old
Pubic hair ____ years old Underarm hair ____ years old

Date of last Pap Smear? ___ / ___ / _____ [ ] Normal [ ] Abnormal
Have you ever had: [ ] Colposcopy [ ] Conization or LEEP of cervix

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Contraceptive History [ ] None
[ ] Condoms – dates of use _______
[ ] Birth Control pills/patch/ring – dates of use _______
[ ] Tubal Sterilization Procedure - date _____________

[ ] IUD – dates of use _______
[ ] Depo Provera – dates of use _______
[ ] Tubes untied year - date _______

Sexual History

How many times do you have sex per week? _____ Is sex painful? [ ] NO [ ] YES [ ] Sometimes
Do you use lubricants during sex? [ ] NO [ ] YES If yes, which one? ___________________

Have you had any of the following pelvic infections? [ ] NO [ ] Yes – check all that apply

[ ] Chlamydia – year _____ [ ] Gonorrhea – year _____ [ ] Herpes – year ______
[ ] Syphilis – year _____ [ ] HIV/AIDS – year ______ [ ] Hepatitis – year _____

Surgical History Have you ever had surgery? [ ] NO [ ] YES - List below in order:

Year	Surgery and Reason and any Complications
_______	____
_______	____
_______	____
_______	____
_______	____
_______	____

Did you have any anesthesia problems? [ ] NO [ ] YES – Describe ______________________________________

Medical History Do you have any medical problems? [ ] NO [ ] YES – Please List

(1) ____
(2) ____
(3) ____
(4) ____
(5) ____

Current Medications or Vitamins? ____
____

Do you have any allergies to medications or foods? [ ] NO [ ] YES If yes please explain __________________
____

Breast Screening
Have you had a mammogram? [ ] NO [ ] YES – date ___ / ___ / _____ Result – [ ] Normal
[ ] Abnormal: Please explain ____

Social History

Caffeinated drinks per day? [ ] NO [ ] YES - how many/day? _______
Do you smoke cigarettes? [ ] NO [ ] YES - how many/day? _______
Do you drink alcohol? [ ] NO [ ] YES - how much/day? _______
Other recreational drugs use? [ ] NO [ ] YES - Describe ___________________________
Do you exercise? [ ] NO [ ] YES - Describe ___________________________

Ethnic Background: [ ] Caucasian [ ] Ashkenazi Jewish [ ] Asian [ ] Native American
[ ] African American [ ] African [ ] Hispanic [ ] Other _________

Review of Systems

General:
[ ] Weight loss or gain
[ ] Anorexia - bulimia
[ ] Lack of energy
[ ] Other _____________
[ ] None

Head, Eyes, Ears Nose Throat:
[ ] Headaches - blurry vision
[ ] Dizziness
[ ] Hearing loss - loss of smell
[ ] Other _____________
[ ] None

Mental Health:
[ ] Depression
[ ] Anxiety Disorder
[ ] Schizophrenia
[ ] Other _____________
[ ] None

Respiratory:
[ ] Shortness of breath - cough
[ ] Asthma
[ ] Pneumonia
[ ] Tuberculosis
[ ] Other _____________
[ ] None

Endocrine/Hormonal:
[ ] Diabetes
[ ] Thyroid problems
[ ] Feeling Hot / Cold
[ ] Excessive thirst / hunger
[ ] Other _____________
[ ] None

Neurological:
[ ] Weakness - loss of balance
[ ] Seizures
[ ] Numbness
[ ] Memory loss
[ ] Other _____________
[ ] None

Gastrointestinal:
[ ] Nausea - Vomiting
[ ] Diarrhea - Constipation
[ ] Irritable bowel syndrome
[ ] Crohn's - ulcerative colitis
[ ] Other _____________
[ ] None

Genito-urinary:
[ ] bladder / kidney infections
[ ] Frequent urination - leaking urine
[ ] Vaginal infection
[ ] Blood in urine
[ ] Other _____________
[ ] None

Skin/Extremities:
[ ] Excess hair growth
[ ] Acne
[ ] Skin cancer
[ ] Moles -change in appearance
[ ] Other _____________
[ ] None

Breasts:
[ ] Discharge
[ ] Lumps [ ] Pain
[ ] Abnormal mammogram
[ ] Reduction - Augmentation
[ ] Cancer
[ ] Other _____________
[ ] None

Hematologic:
[ ] DVT or pulmonary Embolism
[ ] Sickle cell
[ ] Swollen glands - lymph nodes
[ ] Blood Transfusion(s)
[ ] Blood Clotting Disorder - bruising
[ ] Other _____________
[ ] None

Cardiovascular:
[ ] Skipped heart beats
[ ] Chest Pain
[ ] Heart Attack
[ ] Mitral valve prolapse
[ ] Rheumatic fever
[ ] Other _____________
[ ] None

Family History	**Living**	**Cause of Death and Age**
Mother	[ ] Yes – age____ [ ] NO	____________________
Father	[ ] Yes – age____ [ ] NO	____________________
Brother(s)	[ ] Yes – age____ [ ] NO	____________________
Sisters(s)	[ ] Yes – age____ [ ] NO	____________________
Maternal Grandmother	[ ] Yes – age____ [ ] NO	____________________
Maternal Grandfather	[ ] Yes – age____ [ ] NO	____________________
Paternal Grandmother	[ ] Yes – age____ [ ] NO	____________________
Paternal Grandfather	[ ] Yes – age____ [ ] NO	____________________

Disorders in your family:	**Relationship to You**	
Breast Cancer	[ ] YES ________________________	[ ] NO
Ovarian Cancer	[ ] YES ________________________	[ ] NO
Colon Cancer	[ ] YES ________________________	[ ] NO

Disorders in your family:	**Relationship to You**		
Other Cancer _______________	[ ] YES	_________________________	[ ] NO
Diabetes	[ ] YES	_________________________	[ ] NO
Thyroids problems	[ ] YES	_________________________	[ ] NO
DVT / Pulmonary Embolism	[ ] YES	_________________________	[ ] NO
Endometriosis / Infertility	[ ] YES	_________________________	[ ] NO
Early Menopause	[ ] YES	_________________________	[ ] NO
Heart Disease	[ ] YES	_________________________	[ ] NO
Any Birth defects	[ ] YES	_________________________	[ ] NO
Developmental delay	[ ] YES	_________________________	[ ] NO
Neural Tube Defects	[ ] YES	_________________________	[ ] NO
Sickle Cell	[ ] YES	_________________________	[ ] NO
Any genetic disease _______________	[ ] YES	_________________________	[ ] NO

Other – Please specify ____

[ ] None of the above

PRIOR FERTILITY TESTING AND TREATMENT

Have you ever had fertility testing or treatment before? [ ] YES [ ] NO

Prior Tests: (check those that apply)

[ ] Hysterosalpingogram (HSG) Date ___ / ___ / _____ Results ____

[ ] Semen Analysis Date ___ / ___ / _____ Results ____

[ ] FSH Date ___ / ___ / _____ Results ____

Prior Treatments	**# Times**	**Date(s)**	**Outcome**	
Intrauterine Insemination (IUI)	_______	___ / ___ / _____	[ ] Pregnant	[ ] Not Pregnant
Clomid and timed sex	_______	___ / ___ / _____	[ ] Pregnant	[ ] Not Pregnant
Clomid with Insemination (IUI)	_______	___ / ___ / _____	[ ] Pregnant	[ ] Not Pregnant
Injections with Insemination (IUI)	_______	___ / ___ / _____	[ ] Pregnant	[ ] Not Pregnant

In Vitro Fertilization (IVF)

1 Date _________ # eggs_____ # embryos transferred ____# frozen ____ [ ] Pregnant [ ] Not Pregnant

2 Date _________ # eggs_____ # embryos transferred ____# frozen ____ [ ] Pregnant [ ] Not Pregnant

3 Date _________ # eggs_____ # embryos transferred ____# frozen ____ [ ] Pregnant [ ] Not Pregnant

4 Date _________ # eggs_____ # embryos transferred ____# frozen ____ [ ] Pregnant [ ] Not Pregnant

Frozen Embryo Cycles

1 Date _________ # Frozen Embryos transferred ______ [ ] Pregnant [ ] Not Pregnant

2 Date _________ # Frozen Embryos transferred ______ [ ] Pregnant [ ] Not Pregnant

3 Date _________ # Frozen Embryos transferred ______ [ ] Pregnant [ ] Not Pregnant

4 Date _________ # Frozen Embryos transferred ______ [ ] Pregnant [ ] Not Pregnant

PARTNER MEDICAL HISTORY (IF APPLICABLE)

Partner's Sex: [ ] Male [ ] Female

Medical problems: ____

____

Check Any Medical Conditions that Apply to you: [ ] None

[ ] Diabetes Mellitus [ ] Cancer [ ] High Blood Pressure [ ] Urinary Infections

[ ] Multiple Sclerosis [ ] Prostatic Infections [ ] Neurological problem __________________

Current Medications: ____

Allergies to medications or foods: ____

Do you consume caffeinated drinks? [ ] NO [ ] YES - How many/day? ______________

Do you smoke cigarettes? [ ] NO [ ] YES - How many/day? ______________

Do you drink alcohol? [ ] NO [ ] YES - How much/day? ______________

Do you use other recreational drugs? [ ] NO [ ] YES - Describe ____________________

Ethnic Background: [ ] Caucasian [ ] Ashkenazi Jewish [ ] Asian [ ] Native American

[ ] African American [ ] African [ ] Hispanic [ ] Other _________

Disorders in your Family:	**Relationship to You**	
Any Birth Defects	[ ] YES ________________________	[ ] NO
Learning /Developmental Problems	[ ] YES ________________________	[ ] NO
Down Syndrome	[ ] YES ________________________	[ ] NO
Sickle Cell Anemia	[ ] YES ________________________	[ ] NO
Cystic Fibrosis	[ ] YES ________________________	[ ] NO
Neural Tube Defects	[ ] YES ________________________	[ ] NO
Any genetic disease –________________	[ ] YES ________________________	[ ] NO

[ ] None of the above [ ] Other – Please specify ____________________________________

For Male partner (if applicable):

Have you been evaluated by a urologist? [ ] NO [ ] YES

Have you ever conceived a child? [ ] NO [ ] YES

Have you ever had a semen analysis? [ ] NO [ ] YES

Have you had problems with erection or ejaculation? [ ] NO [ ] YES

Have you had trauma / surgery of the penis / testicles? [ ] NO [ ] YES

Do you use hot tubs regularly? [ ] NO [ ] YES

Are you exposed to prolonged heat? [ ] NO [ ] YES

Have you had an infection of the penis, testicle, or scrotum? [ ] NO [ ] YES – Please Specify ___________

Have you had exposure to radiation or chemotherapy? [ ] NO [ ] YES – Please Specify ___________