PALM BEACH FERTILITY CENTER
MARK DENKER, M.D.

Female Patient Medical History

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

Partner Information

Partner's Name _____ Date of Birth _____ Occupation _____

Referring Physician Information

Referring Physician _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Reason for Visit

Why are you seeing the doctor? _____

Surgery History

List all surgical procedures:

Date	Type of Surgery	Length of Stay	Name of Hospital/Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication History

List all medications that you are currently taking:

Medication	Dose	Times per Day	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

List all allergies (medication, food...)

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Past Medical History

Please choose yes or no to each of the following:

Have you been vaccinated against Hepatitis B? ☐ Yes ☐ No

Have you been screened for sickle cell trait? ☐ Yes ☐ No

Are you of Jewish or French Canadian ancestry? ☐ Yes ☐ No

If Yes, have you been screened for Tay-Sachs disease? ☐ Yes ☐ No

Is your partner of Jewish of French Canadian ancestry? ☐ Yes ☐ No

If Yes, has he been screened for Tay-Sachs disease? ☐ Yes ☐ No

Have you been screened for cystic fibrosis? ☐ Yes ☐ No

Has your partner been screened for cystic fibrosis? ☐ Yes ☐ No

Do any genetic disorders run in the family? ☐ Yes ☐ No

Do any genetic disorders run in your partner's family? ☐ Yes ☐ No

Have you ever had a problem with anesthesia? ☐ Yes ☐ No

Have you ever been given antibiotics before dental work? ☐ Yes ☐ No

Do you have a history of any of the following:

Asthma? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

Heart valve disease? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No

Blood transfusions? ☐ Yes ☐ No

Blood clotting disorders? ☐ Yes ☐ No

Anemia? ☐ Yes ☐ No

Thyroid problems? ☐ Yes ☐ No

Seizures? ☐ Yes ☐ No

Migraines? ☐ Yes ☐ No

Hepatitis? ☐ Yes ☐ No

Lupus Erythematosus (SLE)? ☐ Yes ☐ No

Bladder/Kidney infection? ☐ Yes ☐ No

Sexually transmitted diseases? ☐ Yes ☐ No If Yes, Type(s):_____

Pelvic inflammatory disease? ☐ Yes ☐ No

Have you had any complications with previous pregnancies? ☐ Yes ☐ No

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? ☐ Yes ☐ No

Social History

Occupation _____ Ethnic Background_____

Marital Status:

☐ Married (Years: _____) ☐ Domestic Partner (Years: _____) ☐ Single ☐ Divorced ☐ Widowed ☐Separated

Diet: ☐ Regular ☐ Vegetarian ☐ Diabetic ☐ Lo-Carb ☐ Other:_____

Hours of Exercise per Week: ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 4-5 ☐ >5

Alcohol and Cigarette Use

Do you smoke? ☐ Yes ☐ No If Yes, how much do you smoke?_____

Have you smoked >100 cigarettes in your lifetime? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If Yes, how many drinks per week? ☐ 1-2 ☐ 3-4 ☐ 5 or more

Partner's History

Does your partner have children from a previous relationship? ☐ Yes ☐ No Ages: _____

Partner's Occupation _____

Partner's Medical Problems _____

List all medications that your partner is currently taking:

Medication	Dose	Times per Day	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GYN History

Age you started having periods _____ # Days between periods _____# Days of Flow _____

Are your periods regular? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Do you bleed/spot with intercourse? ☐ Yes ☐ No

Do you have menstrual cramps? ☐ Yes ☐ No

☐ None ☐ Mild ☐ Moderate ☐ Severe

What pain medicine do you use?_____

Do you have pelvic or abdominal pain? ☐ Yes ☐ No

If Yes, where is the pain located?_____

What does it feel like?_____

Most recent form of birth control used _____

Other forms of birth control used in the past _____

How often do you have intercourse? _____

Do you use lubricants? ☐ Yes ☐ No

Is intercourse painful or difficult for you? ☐ Yes ☐ No

Date of Last Pap Smear: _____Results: _____ ☐ Normal ☐ Abnormal

Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No If Yes, Date: _____

If Yes, what was the treatment? ☐ None ☐ Cone Biopsy ☐ Cryotherapy ☐ LEEP

Date of last mammogram: _____Results: _____ ☐ Normal ☐ Abnormal

What are your plans for conceiving a child? _____ ☐ As soon as possible ☐ In the future ☐ Never ☐ Unsure

How long have you been trying to conceive? _____

How do you monitor ovulation? List all that apply.

☐ Cervical mucous ☐ Basal Body Temp ☐ Ovulation kit ☐ Don't monitor ☐ Other

If Other, Please Explain: _____

Have you used any of the following infertility treatments? If yes, please list date.

Clomid ☐ Yes ☐ No   Number of cyles __________ Date: __________

Femara (letrozole) ☐ Yes ☐ No   Number of cyles __________ Date: __________

Fertility shots ☐ Yes ☐ No   Number of cyles __________ Date: __________

Inseminations ☐ Yes ☐ No   Number of cyles __________ Date: __________

In Vitro Fertilization ☐ Yes ☐ No   Number of cyles __________ Date: __________

ICSI ☐ Yes ☐ No   Number of cyles __________ Date: __________

Frozen Embryo Transfers ☐ Yes ☐ No   Number of cyles __________ Date: __________

Have you had a hysterosalpingogram (HSG) done? ☐ Yes ☐ No   If Yes, Results? __________ ☐ Normal ☐ Abnormal

Has a semen analysis been done? ☐ Yes ☐ No   If Yes, Results? __________ ☐ Normal ☐ Abnormal

Obstetrical History

In order, starting with your first pregnancy, please answer the following:

Date ________ Outcome (full term birth, preterm birth, miscarriage, ectopic, etc.) __________

Complications__________ Time to Conceive __________

Infertility treatments used __________ Is your current partner the father? ☐ Yes ☐ No

Date ________ Outcome (full term birth, preterm birth, miscarriage, ectopic, etc.) __________

Complications__________ Time to Conceive __________

Infertility treatments used __________ Is your current partner the father? ☐ Yes ☐ No

Date ________ Outcome (full term birth, preterm birth, miscarriage, ectopic, etc.) __________

Complications__________ Time to Conceive __________

Infertility treatments used __________ Is your current partner the father? ☐ Yes ☐ No

Date ________ Outcome (full term birth, preterm birth, miscarriage, ectopic, etc.) __________

Complications__________ Time to Conceive __________

Infertility treatments used __________ Is your current partner the father? ☐ Yes ☐ No

Date ________ Outcome (full term birth, preterm birth, miscarriage, ectopic, etc.) __________

Complications__________ Time to Conceive __________

Infertility treatments used __________ Is your current partner the father? ☐ Yes ☐ No