

Advanced Reproductive Medicine and Surgery, P.C.

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HEALTH QUESTIONNAIRE FOR WOMEN

This record of your past medical history is confidential and will not be given to anyone without your request or permission. Experience has shown that this is a more accurate way of getting a reliable record than to subject you to rapid-fire questions. Of course, I will go over the significant points with you. The accurate completion of the questionnaire will be of great value in helping to understand and properly evaluate your medical and infertility problems. Please use dates whenever possible and print or write legibly.

Name _____ Date _____

Age _____ Birth Date _____ Height: _____ Weight: _____

Address _____

Referring Physician _____

Home Phone _____ Work Phone _____

Describe the reason for your visit: _____

I. MENSTRUAL HISTORY

Age at first period _____ usual days between periods _____ First day of last period _____

Duration of periods _____ Menstrual cramps? Yes No Mild Moderate Severe

What medication do you take for cramps? _____

How do you feel just before your period? Depressed Bloated Irritable Tender Breasts Headache Acne Other

II. REPRODUCTIVE HISTORY

Partner's age: _____ Partners Occupation _____

Children from prior relationship? Husband: Yes No Wife: Yes No

Current methods of contraception? Pills Condoms Foam Diaphragm IUD Withdrawal Rhythm Depo-Provera None

Tubal Ligation _____ Vasectomy _____

If IUD, what kind? _____ Was device removed to conceive? Yes No

Was device removed for complications? Yes No Describe: _____

Pap smear date _____ Results _____

Mammogram date _____ Results _____

Last pelvic exam date _____ Results _____

List any previous Pregnancies:

Year	Time to Conceive	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

III. BACKGROUND INFORMATION

Please circle yes or no if you have experienced any of the following. If yes, please underline the specific problem to which you refer.

1. Chronic headaches, history of head trauma, seizure disorder, problems with sense of smell, visual disturbances, dizziness, loss of balance. YES NO
2. Rapid or marked changes in weight, increased thirst, changes in appetite, increased sweating, chronically warm or cold, history of painful swallowing, change of voice or hoarseness, insomnia, fatigue, tremors, craving for salt, thyroid disease, diabetes, history of breast secretions or milky discharge from nipples. YES NO
3. History of acquired or congenital heart disease, scarlet fever, rheumatic fever, diagnosis or treatment of high blood pressure. YES NO
4. History of pulmonary (lung) disease such as tuberculosis, pneumonia, chronic bronchitis, emphysema, lung cysts, or tumors. YES NO
5. History of gall bladder problems, hiatal hernia, ulcer, appendicitis, colitis, regional enteritis, pancreatitis, jaundice, hepatitis, or liver problems. YES NO
6. History of anemia, need for transfusion, arthritis, kidney infections, nephritis, Bright's disease, urinary tract anomalies, frequent urination, autoimmune disease. YES NO
7. History of syphilis, gonorrhea, Chlamydia, herpes, P.I.D., tubal infection. YES NO
8. History of rape, sexual molestation, or domestic abuse. YES NO If yes, would you like to discuss it? YES NO
9. History or treatment of psychological or psychiatric illness (describe) _____ YES NO
10. History of any other chronic or serious illness (describe). _____ YES NO
11. Do you work? Type of work? _____ YES NO
12. History of depression or anxiety? YES NO
13. Current height _____ Current weight _____
14. Type of diet _____ Type of exercise _____ Frequency _____
15. Do you drink caffeinated beverages? How much daily? _____ YES NO
16. History of an eating disorder (anorexia or bulimia)? _____ YES NO
17. Do you smoke? How many packs a day? _____ For how many years? _____ YES NO
18. Do you drink alcohol? How many drinks weekly? _____ YES NO
19. History of marijuana, opium, cocaine, heroin, or self-injected drugs? YES NO
20. History of therapeutic (not for diagnosis) x-ray treatment anti-cancer drugs or drugs for arthritis? _____ YES NO
21. History of use of tranquilizers or sleeping medications? YES NO
22. Medications used now or recently (list) _____
23. List any drug allergies and reactions _____

Type of surgery	Year	Hospital	Surgeon's Name
_____	_____	_____	_____
_____	_____	_____	_____

25. Previous hospital admissions

Reason	Year	Hospital	Physician's Name
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IV. PSYCHOLOGICAL OR SOCIAL FACTORS

Describe any emotional or sexual problems you would like to discuss. _____

Are you under any unusual emotional stress? (describe) _____

V. FAMILY HISTORY

List any illnesses

Father: Alive _____ Deceased _____ Age _____

Mother: Alive _____ Deceased _____ Age _____

Sisters: Ages _____ Diseases _____

Brothers: Ages _____ Diseases _____

Children (yours) Ages _____ Diseases _____

Children (partners) Ages _____ Diseases _____

Any serious diseases in other relatives? Explain? _____

Had your mother ever been given DES (drug to prevent miscarriage) while pregnant with you? YES NO UNKNOWN

Discuss any birth defects or mental retardation in your families: _____

VI. EXPECTATIONS

And finally, please indicate what your expectations are for your first visit or how you would like me to help?

Do you have any specific or unique problems or requirements (i.e. language barrier, limited availability)?
