REPRODUCTIVE MEDICINE

Patient Name: ______________________________ SS# : ____________________

Address: ______________________________ Phone: ____________________

May we contact you at your home #: ____________ or cell phone #: ____________________

City: ______________ State: __________ Zip: __________ County: ________________

Age: __________ Date of Birth: ______________________ Sex: ______________

Employer: ______________________________ Effective Date: ______________

Phone: ________________________ may we contact you at this number: __________

Address: ____________________ City: __________ State: ________ Zip: __________

Reason for visit: ______________________________ ____________________

Number of children Living: __________ Number of miscarriages: __________ Pregnant: ________

Parent or Spouse: ______________________________ SS# : ____________________
(circle one)

Address: ______________________________ Phone: ____________________

City: ______________ State: ________ Zip: __________ County: ________________

Age: __________ Date of Birth: ______________________ Sex: ______________

Employer: ____

Phone: ________________________ Effective Date: ______________________

Address: ______________________________ City: ______________ State: ______

In case of Emergency notify: ____
(other than spouse)

Relationship to patient: ____________________ Phone: ______________________

Consulting Physician: ________________________ Last seen: ________________

Address: ______________________________ Phone: ____________________

I HEREBY AUTHORIZE ASSINGMENT OF BENEFITS TO PHYSICIAN'S PRACTICE GROUP FOR MEDICAL SERVICES RENDERED AND THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

______________________________ ____________________
Signature of Patient or Responsible Party Date

I WILL ASSUME COMPLETE RESPONSIBILITY FOR THE COST OF SERVICES RENDERED REGARDLESS OF MY INSURANCE CONTRACTS INCLUDING DEDUCTIBLES, COPAYS, AND NON-COVERED SERVICES.

______________________________ ____________________
Signature of Patient or Responsible Party Date

Name____ **Date** ______________________

Medicines:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Allergies to medicines? __________________________

If so, to what medicines? ____

Social history:

Occupation: ________________________

Smoke: ________ If so, how much?________

Alcohol: ________ If so, how much?________

Drugs _______________________________

Review of Systems – Place a check if you have had a recent problem in:

	Yes	No
1. Weight loss greater than 10 pounds	☐	☐
2. Bad skin rashes or itching	☐	☐
3. Bad headaches	☐	☐
4. Blurred vision or visual problems	☐	☐
5. Diabetes	☐	☐
6. High blood pressure	☐	☐
7. Heart trouble	☐	☐
8. Rheumatic fever	☐	☐
9. Heart mur mur	☐	☐
10. Chest pain	☐	☐
11. Palpitations	☐	☐
12. Asthma	☐	☐
13. Shortness of breath	☐	☐
14. Tuberculosis	☐	☐
15. Gall bladder problems	☐	☐
16. Breast lumps or pain	☐	☐
17. Hepatitis	☐	☐
18. Liver trouble	☐	☐
19. Ulcers	☐	☐
20. Stomach pain	☐	☐
21. Colitis	☐	☐
22. Excessive diarrhea	☐	☐
23. Constant diarrhea	☐	☐
24. Bright red blood in stools	☐	☐
25. Black, tar-like stools	☐	☐
26. Bladder infections	☐	☐
27. Kidney infection	☐	☐
28. Kidney stones	☐	☐
29. Stop bleeding when cut	☐	☐
30. Blood clot in legs or lungs	☐	☐
31. Depression or mental illness	☐	☐

Past Surgery

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Past Medical History

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Obstetric History (include all pregnancies starting from first)

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

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____

Do you have any reason to believe you could have HIV?

Have you ever been hurt (physically or mentally) by your partner?__________________

Gynecologic History

1. Age of first menstrual period __________________
2. Length of period (in days) __________________
3. Cramps: ☐ Mild ☐ Moderate ☐ Severe
4. Interval (from first day of one period to the first day of the next period) __________________
5. Date of last pap smear ______ Abnormal pap ever?______
6. Have you ever had chlamydia? __________________
   gonorrhea?__________________
7. Have you ever had a mammogram? __________________

Genetic History

Name____ **Date** ____________________

Are any of your blood relatives:	Yes	No	Your partner's family (if desiring fertility): Yes	No
English, Irish:	☐	☐	☐	☐
Mediterranean:	☐	☐	☐	☐
(Greek, Italian)	☐	☐	☐	☐
Ashkenazi Jewish:	☐	☐	☐	☐
French Canadian:	☐	☐	☐	☐
African Descent:	☐	☐	☐	☐

Does anyone in your family have:			Your partner's family	
Mental retardation:	☐	☐	☐	☐
Down syndrome:	☐	☐	☐	☐
Open spine defects (spina bifida, anencephaly)	☐	☐	☐	☐
Cystic fibrosis:	☐	☐	☐	☐
Sickle cell anemia:	☐	☐	☐	☐
Thalassemia:	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐
Birth defects:	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐

Male Information: Medical Problems ____________________ Medications ____________________
Allergies ____________________ Alcohol _______ Smoking _______ Drugs _______
Occupation ____________________ Previous evaluation ____________________

Please do not write below this line.