Reproductive Partners
MEDICAL GROUP, INC.

HISTORY

NAME_____**DATE**_____**AGE**_____
LAST MENSTRUAL PERIOD_____
PAST MEDICAL HISTORY (List past significant illnesses and dates) _____
_____
_____
_____
SURGERY (List operations and dates) _____
_____
_____
_____
CURRENT DRUGS AND MEDICATIONS_____
_____
_____
_____
ALLERGIES_____
_____

MENSTRUAL HISTORY

AGE OF ONSET_____**CYCLE**_____ (Number of days from start of one period to the start of the next)
Length of periods_____ **Menstrual cramps** [ ] Mild [ ] Moderate [ ] Severe
Menstrual Flow [ ] Light [ ] Normal [ ] Heavy **Pre-menstrual symptoms** [ ] Yes [ ] No

PREGNANCIES

Total Number_____ **Number Full Term Births**_____ **Premature births**_____
Miscarriages_____ **Abortions**_____ **Number of Living Children**_____

SOCIAL HISTORY

Smoke Cigarettes [ ] Yes [ ] No How Much? _____ **Drink alcohol** [ ] Yes [ ] No How Much?_____ **Use drugs** [ ] Yes [ ] No Type? _____ How Often? _____
Birth control [ ] Yes [ ] No Type? _____ If Pills, Name_____
Last pelvic exam_____ **Last Pap smear**_____

FAMILY HISTORY

[ ] **Diabetes** [ ] **Tuberculosis** [ ] **Heart Disease** [ ] **Breast Cancer** [ ] **Ovarian Cancer**
(Both Partners) [ ] **Cystic Fibrosis** [ ] **Hemophilia** [ ] **Tay-Sacks** [ ] **Mental Retardation**
[ ] **Other Genetic**

TESTS AND TREATMENTS

[ ] **Semen Analysis** [ ] **Tubal Dye Test** [ ] **Hormone Tests** [ ] **Post Coital Test** [ ] **Clomid**
[ ] **Other Fertility Drugs** [ ] **Insemination** [ ] **IVF** [ ] **ICSI** [ ] **PGD**

ANY OTHER PROBLEMS YOU WISH TO DISCUSS

[ ] **Sexual problems** [ ] **Verbal/Physical Abuse**
[ ] **Other**_____