University Reproductive Associates

Patient Questionnaire Date: _______________

Please take a few minutes to answer these questions as completely as possible. Thank you

Name: ____ Occupation: ________________________

Partnerøs Name: _______________________________________ Occupation: _________________________

Doctor referred you here: ____

Gynecological History:

First day of your last menstrual period: _______________________________

Age when cycle began: _______________ Length of periods (Days of flow): ___________________

Length of cycle (Time from the start of one period until the start of next): _______________________

Last PAP smear: Date _________________ Result ____________________

Pregnancy History:

Number of Miscarriages: _______________________ Year(s): ___________________

Number of children: ___________________________ Year(s): ___________________

Medical/Surgical History:

Allergies: Denies Latex Contrast Dye Food ________________

Medications:____

Other:____

Explain Reaction:____

Do you have any medical conditions or problems? (if yes, please explain)

____

____

Have you had any surgery? (operation/year)

____

____

Do you take any medications, vitamins, or herbal supplements? (please list)

____

____

Do you smoke cigarettes? (packs per day x number of years) _______________________________

Do you drink alcohol? (number of drinks in an average week) _______________________________

Do you use any street drugs? (marijuana, cocaine, etc.) ___________________________________

Family History (Parents, Grandparents, Siblings, Aunts, Uncles, etc.)

Breast Cancer	no___	yes___	(who/age it occurred)__________________
Ovarian Cancer	no___	yes___	(who/age it occurred)__________________
Uterine Cancer	no___	yes___	(who/age it occurred)__________________
Colon Cancer	no___	yes___	(who/age it occurred)__________________
Birth Defects	no___	yes___	(who/age it occurred)__________________
Osteoporosis	no___	yes___	(who/age it occurred)__________________
Diabetes	no___	yes___	(who/age it occurred)__________________
High Blood Pressure	no___	yes___	(who/age it occurred)__________________

Other family diseases ____

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