NASHVILLE FERTILITY CENTER, P. C.

345 23rd Ave. North, Suite 401, Nashville, TN 37203 (615) 321-4740 FAX (615) 320-0240

MEDICAL HISTORY: EGG DONOR (*Please PRINT*)

NAME ____**Date** ____________________

Date of Birth ______________________ **Age** __________ **Social Security Number** ________________________

Who referred you to us? ______________________________________ **Have you seen our web site?** _________

What is your primary reason for seeing us today? ____

____

____

CONTRACEPTIVE HISTORY

Please check (X) all types of birth control used (past or present)

	Method	Dates Used			Method	Dates Used	
		From	To			From	To
	Birth Control Pills				Diaphragm		
	IUD				Natural Method		
	Condom/foam				Other		

OBSTETRICAL HISTORY

Please list all pregnancies and outcome (ectopic, miscarriages, delivery and abortions)

No	Completion Date	Pregnancy outcome	Type Delivery	Birth wt.	Sex	Time to conceive	Complications
1							
2							
3							
4							
5							
6							

INTERCOURSE HISTORY

How often do you have intercourse (per week)? ________________________ Lubricants used? ___ Yes ___ No
Does husband ejaculate during intercourse ___ Yes ___ No Is intercourse painful to either partner ___ Yes ___ No
Any problems with intercourse? ____

PAST SURGICAL HISTORY

Date	Procedure	Physician

PAST MEDICAL HISTORY

List any medical problems that you have:

List any sexually transmitted diseases (syphilis, gonorrhea, vaginal warts, herpes, PID, etc.) you have had:

Have you ever had a blood transfusion? __________

Have you ever been exposed to toxic chemicals and/or radiation? ___________________________

List any medications you are taking:

Medication	Dosage	Reason

REVIEW OF SYSTEMS

Do you now have or have you had any problems with:

	Yes	No	Explain		Yes	No	Explain
Head Injury				Hepatitis			
Seizures				Appendicitis			
Eyes				Abdominal pain			
Ears, Nose				Liver			
Mouth, Throat				Skin/Breast			
Asthma/Allergy				Blood			
Breathing				Depression			
Heart Disease				Arthritis			
Hypertension				Thyroid/Adrenal			
Kidney				Diabetes			
Bladder				Hot Flashes			
Gallbladder				Vaginal discharge			
Nausea				DES Exposure			
Vomiting				Abnormal PAP			
Diarrhea				Weight change			

SOCIAL HISTORY

Do you:

Work? ____ Type of work _________________________________

Smoke? ____ How much ________ packs/day

Use Alcohol? ______________________________________ How much ____________________________________

Use Caffeine? _____________________________________ How much ____________________________________

Use non-prescribed Drugs? ____________________________ Which drugs _________________________________

(cocaine, marijuana, etc) ____

Exercise? ____ Describe ____________________________________

Are you on a special diet? ____________________________ Describe ____________________________________

Marital status: single _____ married _____ divorced _____other _____ comments ____________________________

FAMILY HISTORY

Please check (x) in the appropriate box for the relative involved

Please check if you are adopted ________

	Mother	Father	Bro/Sis	GP	Cousin		Mother	Father	Bro/Sis	GP	Cousin
Miscarriages						Uterine Cancer					
Early Menopause						Breast Cancer					
Endometriosis						Ovarian Cancer					
Irregular periods						Other Cancer					
Infertility						Heart Disease					
Stillbirth						Hypertension					
Birth Defects						Diabetes Mellitus					
Spinal Bifida						Thyroid Disease					
Excess Hair Growth						Adrenal Disease					
Blood Clots						Other (Specify)					