Infertility Patient History Form

Patient Name	:	Reshma Siya				Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	:	1995-05-21	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Gyenec Test	Date	:	2024-02-19

Spouse's Name :

AGE :

Years Married/Together :

Years Trying to get Pregnant :

Prior Marriage(s)for Patient. :

Patient's # of Children/Ages. :

Prior Marriage(s) for Spouse :

Partner's # of Pregnancies :

#of Children/Ages :

CHIEF COMPLAINT(What is the main reason for your visit today?)

PAST MEDICAL & SOCIAL HISTORY

PATIENT

Any brother(s)/ages:

Any serious family illnesses:

Age at Puberty:

Any History of(Y/N, Date):

Undescended Testicle:

Hernia Surgery:

Vasectomy:

Varicocele:

Surgery on the testicle/scrotum/penis:

Testicular Trauma/bruising/injury:

Recent Fever:

Urinary Tract Infection(s):

Prostatitis:

Sexually Transmitted Diseases:

Mumps:

Tuberculosis:

Exposure to chemicals:

Radiation:

Erectile Dysfunction:

List Any Medical Problems/Surgeries/Dates:

Medications:

Allergies:

Tobacco:

Alcohol:

Drugs:

Employment:

Frequency of sex?:

Lubricants:

Masturbation?:

Spouse's Gynecologist's Name:

Address:

Phone Number:

SPOUSE

List Any Medical Problems/Surgeries/Dates:

Medications:

Allergies:

Tobacco:

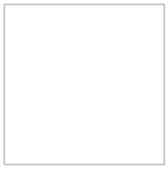
Alcohol:

Drugs:

Employment:

How often do your menstrual cycles occur (Days):

Have you had a female infertility evaluation? Tests? Please describe:

Sign here, only if all of your questions have been answered to your satisfaction	
Patient	Doctor
	
Patient Name Reshma Siya Date 2024-02-19	Doctor Name Gyenec Test - Gynaecology (S6) Date 2024-02-19