DOXOLOGY
HEALTH & FERTILITY

Name:
DOB:
MRN:

Reason for visit: ____

General Medical History

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Colitis
- ☐ Ulcers
- ☐ Recurrent Urinary Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Diabetes/Prediabetes
- ☐ Thyroid disease
- ☐ Skin disease
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Cancer _____________
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Varicose Veins
- ☐ Blood clot in the legs or lungs
- ☐ Bleeding disorder
- ☐ Migraines
- ☐ Seizure
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Drug dependency
- ☐ Alcohol dependency
- ☐ Depression
- ☐ Attempted Suicide
- ☐ Anxiety
- ☐ Other ___________________ ___________________

Colonoscopy: ________

Urologic History

- ☐ Trichomonas
- ☐ Genital Lesions
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphilis
- ☐ HIV
- ☐ Colon cancer
- ☐ Infertility
- ☐ Erectile dysfunction
- ☐ Lack of sexual desire

Are you and your partner avoiding pregnancy: ❑N ❑Y
If no, what method do you use to avoid pregnancy?______________________

Surgeries

Date/Year	Surgery	Surgeon/Location	Location

Have you ever had surgery or anesthesia complications? (Please describe)
____

Allergies: ____

Current Medications/Supplements and Dosages:
____
____

Name:
DOB:
MRN:

Family History:

Has anyone in your family every had:

- ☐ Breast cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Colon cancer
- ☐ Heart disease
- ☐ Diabetes
- ☐ Autoimmune disease
- ☐ Blood clots
- ☐ Depression

Social History (please circle)

Marital status (circle): Single, Engaged, Married, Separated, Divorced

Sexually active (circle): Y N

Do you have sex with (circle): Men Women Both

Have you ever smoked (circle)? Y N If yes, for how many years? ______

Do you smoke now (circle)? Y N How many packs per day? _____

Do you drink alcohol (circle)? Y N If yes, please circle: beer wine liquor

How many times a week do you drink alcohol? ________ How many drinks at a time? _________

How many times a week do you exercise? ______ What kind of exercise? ___________________

Occupation: _______________________________________

Children (list names, ages): ____

Who do you live with? ____

Do you feel safe at home? ____