



Reproductive Associates of Delaware

NEWARK • DOVER • WILMINGTON

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 4735 Oglethorpe-Stanton Road
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 Medical Director,
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FEMALE HEALTH QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____

Race: _____ Religion: _____ Blood type: _____

Reason for visiting our office today: _____

PREGNANCY HISTORY

Number of previous pregnancies _____

Number of previous abortions _____

Number of previous miscarriages _____

Number of previous tubal pregnancies _____

Number of living children _____

Number of previous preterm births _____

PREGNANCY RECORD

Delivery date	Type of delivery (vaginal/c-section)	Birth weight	Pregnancy Complications

Name: _____

MENSTRUAL HISTORY

Age period started?	
Last menstrual period?	
Period prior to that?	
Usual days between periods?	
Flow (circle one):	light medium heavy
Duration of flow?	
Discomfort with periods?	
When in cycle does discomfort occur?	

CURRENT MEDICATION/VITAMINS

Medication	Frequency	Reason

Allergies to medications? _____

Other allergies? _____

Do you have cats? _____

Are you immune to German measles or rubella? Yes No Not Sure

Have you ever had a blood transfusion? Yes No

Last pap test? _____

History of abnormal pap? Yes No

Date and treatment of abnormal pap? _____

SEXUAL HISTORY

Average number of times per week that you have sexual intercourse? _____

Do you have pain during intercourse? Yes No

Do you use and lubricants during intercourse? _____

Do you douche? Yes No

When? _____

Are you having any problems that you want to discuss? Yes No

Name: _____

PAST HISTORY

Previous testing for infertility:

Date	Physician	Test	Results

PREVIOUS SURGERY

Date	Physician	Surgery	Reason	Complication

Please check if you have ever had any of the following:

<input type="checkbox"/>	Head injury	<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	Eye or vision problem	<input type="checkbox"/>	Bladder/Kidney disease
<input type="checkbox"/>	Ear or hearing problem	<input type="checkbox"/>	Kidney stone
<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Epilepsy or convulsions	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	German Measles
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Blood clot in legs or lung	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Rheumatic or Scarlet Fever	<input type="checkbox"/>	Vaginal infections
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Venereal warts
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Sexual transmitted disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Tubal/Pelvic pain
<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Hepatitis or yellow jaundice	<input type="checkbox"/>	Birth defect
<input type="checkbox"/>	Ulcers or stomach problems	<input type="checkbox"/>	Gallbladder disease
<input type="checkbox"/>	Bowel problems	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Other psychiatric disorders	<input type="checkbox"/>	

Name: _____

FAMILY HISTORY:

		Who In Family?
<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	High blood pressure	
<input type="checkbox"/>	Heart disease	
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	Birth defects/mental retardation	
<input type="checkbox"/>	Kidney/Urinary disease	
<input type="checkbox"/>	Mental illness	
<input type="checkbox"/>	Hemophilia	
<input type="checkbox"/>	Asthma/Allergy	
<input type="checkbox"/>	Twins/Triplets	
<input type="checkbox"/>	Epilepsy/Convulsions	
<input type="checkbox"/>	Other	

SOCIAL HISTORY

Hobbies: _____

Alcohol: _____ Tobacco: _____ Recreational Drugs: _____

Exercise and frequency _____

Have you ever received counseling? Yes / No
If so, for what reason? _____

NUTRITIONAL HISTORY

Please describe what you consume on a daily basis. We encourage patients to keep a food journal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Structured Diet Plan: _____

Diet Pills: _____



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Please take a moment to complete this referral form. Thank you!

Patient Name: _____

 Email: _____

OB/GYN Physician: _____

 Family Doctor / Primary Care Physician: _____

Please indicate which of the following sources MOST INFLUENCED your decision to contact us and seek care (CHOOSE ONE):

Patient Referral: _____

Referring OB/GYN: _____

- Delaware Today
- Facebook
- Fertility Assessment on RAD website
- Google Ad
- Google Search
- Insurance Company
- Newsletter

- RAD Website
- Radio Ad – WJBR 99.5
- Radio Ad – WSTW 93.7
- Twitter
- Women’s Journal
- Word of Mouth
- Other: _____

Please circle ALL of the following sources where you have heard/seen about RAD:

- Christiana Care Employee
- Co-worker
- Community Newspaper
- Delaware TV Program
- DOCS
- Dover Air Force Base
- Embryos Alive
- Facebook
- Family Member
- Friend
- Google

- Insurance Company
- Local Book
- Newsletter
- Online – Google Ad
- Online – Google Search
- Online – Other: _____
- Pt Education Seminar
- RAD Employee: _____

- RAD Patient: _____
- RAD Website
- Twitter
- Verizon Yellow Pages
- WJBR (Radio Ad)
- Women’s Journal
- Word of Mouth
- WSTW (Radio Ad)
- Yellow Book