The MacLeod Laboratory

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Medical History Form

Personal Information:

	Husband	Wife
Last Name, First Name:		
Address		
Home Phone:		
Business Phone:		
Referring Doctor:		
Age:		
Height/weight:		
Race:		
Occupation:		

Medical History:

High Blood Pressure	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes:	Yes ☐ No ☐	Yes ☐ No ☐
Hepatitis (in past):	Yes ☐ No ☐	Yes ☐ No ☐
Colitis:	Yes ☐ No ☐	Yes ☐ No ☐
Thyroid Disease:	Yes ☐ No ☐	Yes ☐ No ☐
Allergies:		
Early childhood diseases:		

Medication:

List all drugs currently taken:		
List all antibiotics ever taken:		

Lifestyle:

Alcohol consumption:		
Smoking (# of cigarettes/day):		

Male/Female Specific Medical History:

Male		Female	
Occasional burning (on urination):	Yes ☐ No ☐	Barotholin Duct Cyst:	Yes ☐ No ☐
Discharge from penis:	Yes ☐ No ☐	Vaginitis:	Yes ☐ No ☐
History of non-specific urethritis:	Yes ☐ No ☐	Cervicitis:	Yes ☐ No ☐
Prostatitis (describe therapy):	Yes ☐ No ☐	Endometriosis:	Yes ☐ No ☐
Epididymitis:	Yes ☐ No ☐	Myoma, fibroid tumors:	Yes ☐ No ☐
Inflammation of the testes (with pain and fever):	Yes ☐ No ☐	Infection in pelvis/tubes:	Yes ☐ No ☐
Blood in semen (ever):	Yes ☐ No ☐	Bladder infection:	Yes ☐ No ☐
Blood in urine:	Yes ☐ No ☐	Kidney infection:	Yes ☐ No ☐
Gonorrhea infection:	Yes ☐ No ☐	Gonorrhea infection:	Yes ☐ No ☐
Childhood history of urinary tract infection:	Yes ☐ No ☐	Childhood history of urinary tract infection:	Yes ☐ No ☐
History of surgery as a child:		History of surgery as a child:	
Bladder infection:	Yes ☐ No ☐	Delayed periods:	Yes ☐ No ☐
Kidney infection:	Yes ☐ No ☐	As if you were pregnant:	Yes ☐ No ☐
History of syphilis:	Yes ☐ No ☐	Periods stopped:	Yes ☐ No ☐
History of trichomonas:	Yes ☐ No ☐	Decreasing amount of blood during menses:	Yes ☐ No ☐
Undescended testis:	Yes ☐ No ☐	Increasing amount of blood during menses:	Yes ☐ No ☐
Cancer of testis:	Yes ☐ No ☐	Developed pain during menstruation:	Yes ☐ No ☐
Varicocele:	Yes ☐ No ☐	Premenstrual tension:	Yes ☐ No ☐
Post nasal drip:	Yes ☐ No ☐	Breast tenderness:	Yes ☐ No ☐
Sinus trouble:	Yes ☐ No ☐	Sinus trouble:	Yes ☐ No ☐
Chronic chest cold:	Yes ☐ No ☐	Chronic chest cold:	Yes ☐ No ☐
Herpes – oral or genital:	Yes ☐ No ☐	Herpes – oral or genital:	Yes ☐ No ☐

Family Medical History:

	Husband	Wife
Age of your father:		
Age of your mother:		
# of older brothers/sisters:		
# of younger brothers/sisters:		
Were you born prematurely?		

On time? Late?		
Did your mother have any complications while pregnant with you?		
Did your mother have miscarriages before or after you?	Yes ☐ No ☐	Yes ☐ No ☐
How much did you weigh at birth? (lbs/kgs)		
Did your mother take DES while pregnant with you?	Yes ☐ No ☐	Yes ☐ No ☐
Did your mother have a hysterectomy? Why?	Yes ☐ No ☐	Yes ☐ No ☐
Did your father have any prostate problem?	Yes ☐ No ☐	Yes ☐ No ☐
Do any of your brothers or sisters have fertility problems?	Yes ☐ No ☐	Yes ☐ No ☐
Were you a colicky child?	Yes ☐ No ☐	Yes ☐ No ☐
Did you have any childhood allergies?	Yes ☐ No ☐	Yes ☐ No ☐
Any chronic infections in childhood?	Yes ☐ No ☐	Yes ☐ No ☐
Any birth defects?	Yes ☐ No ☐	Yes ☐ No ☐

Parents Medical History:

	Husband	**Wife**
Have your parents ever had any of the following conditions?		
Heart disease:		
Diabetes:		
High blood pressure:		
Malignancy:		
Arthritis:		
Gall bladder disease:		
Gout:		
Liver problems:		
Kidney problems:		

Pregnancy History:

	Husband	**Wife**
# in previous marriage:		
# in current marriage:		
Children born:		
Induced abortion:		
Miscarriages:		
Premature delivery:		
Birth defect:		

Childhood Medical History:

	Husband	Wife
As a child did you have:		
Tonsillectomy before age 10:	Yes ☐ No☐	Yes ☐ No ☐
Ear infections:	Yes ☐ No☐	Yes ☐ No ☐
Adolescent acne:	Yes ☐ No☐	Yes ☐ No ☐
Many cavities before age 2:	Yes ☐ No☐	Yes ☐ No ☐
For wife only:		
How old were you when you started menstruating?		
How many days apart do you menstruate? (28-30)?		
How long do you bleed? (3,4,5 days?)		
Do you know on which day of your cycle you ovulate?		

Other Information: