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MYTHYROIDMD
HUGH D. MELNICK MD,FACOG
PH: 212-369-8700
FAX: 212-289-8461
MYTHYROIDNYC@GMAIL.COM
www.mythyroidmd.com
1625 Third Avenue
New York, New York 10128

MYTHYROIDMD

IN VITRO FERTILIZATION CENTER
HYPOTHYROIDISM
HORMONAL BALANCE

PATIENT'S MEDICAL QUESTIONNAIRE

(PLEASE FILL ALL PAGES TO THE BEST OF YOUR ABILITY)

NAME:____ **DATE OF VISIT:**________________
LAST NAME, FIRST NAME MI

HEIGHT:__________(FT) **WEIGHT:**____________(LBS) **D.OB**______________ **AGE:**__________

PAST/CURRENT MEDICAL HISTORY

1. **MEDICAL HISTORY:** PLEASE INDICATE **YES OR NO** FOR THE FOLLOWING OPTIONS.

- **DIABETES** ☐YES ☐NO
- **HIGH BLOOD PRESSURE** ☐YES ☐NO
- **CHOLESTEROL** ☐YES ☐NO
- **HEART CONDITION** ☐YES ☐NO
- **THYROID PROBLEMS** ☐YES ☐NO
- **BREAST CANCER OR A LUMP** ☐YES ☐NO
- **URINARY PROBLEMS (PAIN OR FREQUENCY)** ☐YES ☐NO

IF NOT LISTED PLEASE INDICATE BELOW:

____

____

2. **CURRENT MEDICATION(S):**____

   A. **PAST MEDICATION(S):**____

   B. **ALLERGIES TO MEDICATION(S):**__________________________________

3. **SURGICAL HISTORY:**____

4. **GYNECOLOGICAL HISTORY:** IF NOT APPLICABLE PLEASE NOTE N/A.

   A. **PREVIOUS PREGNANCY/PREGNANCIES:**

   LIVE BIRTH(S):_______ **STILLBIRTH(S):**________ **MISCARRIAGE(S):**________
   MISCARRIAGE(S) AFTER 10 WEEKS:__________ **EARLY BIRTH(S):**_________
   ECTOPIC PREGNANCY:_________

   B. **PREVIOUS FERTILITY TESTS/TREATMENTS: EG: BLOOD WORK, SONOGRAMS, IUI OR IVF:**

   ____

   C. **LAST MENSTRUAL PERIOD (LMP):** _______________________________

SYMPTOM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS

Symptom	Yes	No	COMMENTS:
FATIGUE	☐ YES	☐ NO	
DEPRESSION	☐ YES	☐ NO	
WEIGHT GAIN	☐ YES	☐ NO	
DIFFICULTY LOSING WEIGHT	☐ YES	☐ NO	
WATER RENTENTION	☐ YES	☐ NO	
SENSITIVITY TO COLD	☐ YES	☐ NO	
COLD HANDS/FEET	☐ YES	☐ NO	
HAIR LOSS	☐ YES	☐ NO	
DRY HAIR	☐ YES	☐ NO	
DRY SKIN	☐ YES	☐ NO	
BRITTLE NAILS	☐ YES	☐ NO	
LOW SEX DRIVE	☐ YES	☐ NO	
MUSCLE/JOINT PAIN	☐ YES	☐ NO	
POOR MEMORY	☐ YES	☐ NO	
DIFFICULTY CONCENTRATING OR AADD	☐ YES	☐ NO	
CONSTIPATION	☐ YES	☐ NO	
RINGING/TICKING IN EARS	☐ YES	☐ NO	
TREMOR OR SHAKING	☐ YES	☐ NO	
PALPITATIONS/IRREGULAR HEARTBEAT	☐ YES	☐ NO	
SWEATY	☐ YES	☐ NO	
NERVOUSNESS/ANXIETY	☐ YES	☐ NO	
SLEEP DISTURBANCE	☐ YES	☐ NO	
EXCESS BODY OR FACIAL HAIR	☐ YES	☐ NO	
ACNE	☐ YES	☐ NO	

NOTES/ COMMENTS: