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Richard M. Levin, M.D., PSC. / www.babies-by-levin.com / 1-800-766-0304 / fax 1-502-589-3842

Please fill in this form completely!

	Patient	Significant Other
Name:		
Address:		
City/State/Zip:		
Home Phone:		
Cell Phone:		
Date of birth:		
Social Security:		
E-mail Address:		

	Patient's Job	Significant Other's Job
Company:		
Address:		
City/State/Zip:		
Work Phone:		
Job Description:		

	Emergency Contact	Next of Kin
Name:		
Address:		
City/State/Zip:		
Phone:		

	Previous Fertility Doctor	Referring Person
Name:		
Address:		
City/State/Zip:		
Work Phone:		

How did you find us?

- ☐ Friend referred me — Who? _____
- ☐ Doctor referred me — Who? _____
- ☐ Yellow pages — What City/State? _____
- ☐ Internet — Where? _____
- ☐ Television — Where? _____
- ☐ Billboard — Where? _____
- ☐ Support group — Which one? _____
- ☐ Other — Where? _____

By submitting this form I agree to all business terms and conditions located at www.babies-by-levin.com/consent_reversal.htm

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Please fill in this form completely!

Complete Name: _____ Date: _____ Age: _____

◯ Married ◯ Engaged ◯ Single ◯ Divorced ◯ Widowed

How can we help you? Please explain fully!

Gynecologic History

Pregnancies: ____ # Miscarriages: ____ # Abortions: ____ # Living Kids: ____ # Deceased Kids: ____

Date period started: _____ Date previous period started: _____

My periods come as close as every: _____ Days and as far apart as every: _____ Days

I bleed as short as: _____ Days or as long as every: _____ Days

_____ have bad cramps with my periods. _____ have increase frequency of urination with my periods.

_____ have pain with sex. _____ have loose stools or diarrhea with my periods.

Pap Smear History

My last pap smear was in _____ _____ I have _____ had an abnormal pap smear.

To treat my abnormal pap smear I have had: ☐ Nothing ☐ Freezing ☐ Cautery ☐ Leep ☐ Conization ☐ Culposcopy

Sexual History

How often do you have intercourse? _____ times per week.

Do you use lubricants with sex? ◯ Yes ◯ No If "yes", what type: _____

Husband takes "hot baths"? ◯ Yes ◯ No If "yes", how often: _____

Infertility Studies Performed: Applicable? ◯ Yes ◯ No

Test Name	Year Done	Results

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Wife's Review of Systems - Applicable? ○ Yes ◉ No

Please list any of the conditions below that you have had:

Click arrow to select

Other:

Wife's Social History:

What type of work do you do?

Do you smoke?

If "yes" how many packs per day

Do you drink alcohol?

If "yes" how many drinks per week

Do you use illicit drugs?

If "yes" what type

Wife's Medical History - Applicable? ○ Yes ◉ No

Date	Type of medical disease

Wife's Surgical History - Applicable? ○ Yes ◉ No

Date	Type of surgical procedure

Current Medications - Applicable? ○ Yes ◉ No

Drug/Substance Allergies & Reactions- Applicable? ○ Yes ◉ No

○ Yes ◉ No Are you allergic to latex?

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Spouse's Review of Systems: Applicable? ○ Yes ◉ No

Please list any of the conditions below that you have had:

Click arrow to select

Other:

Spouse's Social History:

What type of work do you do?

Do you smoke?

If "yes" how many packs per day

Do you drink alcohol?

If "yes" how many drinks per week

Do you use illicit drugs?

If "yes" what type

Spouse's Medical History - Applicable? ○ Yes ◉ No

Date	Type of medical disease

Spouse's Surgical History - Applicable? ○ Yes ◉ No

Date	Type of surgical procedure

Current Medications - Applicable? ○ Yes ◉ No

Drug/Substance Allergies & Reactions - Applicable? ○ Yes ◉ No

○ Yes ◉ No Are you allergic to latex?