

MEDICAL HISTORY FOR FERTILITY PRESERVATION

Patient Last Name		First Name	Middle Initial
Date of Birth: Male <input type="checkbox"/>	Female <input type="checkbox"/>	Current Age	Social Security Number
Current Diagnosis:			
Treatment with dates: (check all that apply) _____ Chemotherapy _____ _____ Radiation _____ _____ Bone Marrow Transplant _____ _____ Surgery: (please explain) _____			
_____ Treatment not started yet. Scheduled to start: _____			
Past Medical History:			
Do you have any other significant medical/health problems? _____ Yes _____ No If yes, please describe: _____ _____			
Any past surgeries? _____ Yes _____ No If yes, please describe: _____ _____			
What medications are you now taking? _____ NONE _____ LISTED BELOW: _____ _____ _____			
Are you allergic to any medications? _____ Yes _____ No If yes, please list medication and type of reaction: _____ _____			
Do you have any other allergies? _____ Yes _____ No If yes, please list: _____ _____			
Please list any other information that you think we need to know to help you with fertility preservation:			