BBIVF

PATIENTS NAME:	**DATE: / /**
AGE:	**DOB: / /**
Occupation:	
How many times have you been pregnant?	
How many children do you have?	
If you have had other pregnancies, what happened?	
Is your Pap Smear up to date? **YES / NO**	
When did your last period start? / /	
How long have you been with your partner?	
How long have you been trying to fall pregnant for?	
From the beginning of one period to the beginning of the next, what is the longest time between periods?	
From the beginning of one period to the beginning of the next, what is the shortest time between periods?	
How many days do you typically bleed for?	
Do you have any medical problems?	
Have you had any operations before?	
Are you on any medications?	
Do you take some form of Folic Acid?	
Are you allergic to anything?	
Do you smoke? **YES / NO**	
Are there any illnesses in your family?	
Have you used drugs to ovulate before?	
Have you done insemination before? **YES / NO**	
Have you done IVF before? **YES / NO**	
If you have done IVF, how many egg collections have you done?	
Have you been pregnant from IVF before?	
How many times have you been pregnant with IVF?	
Do you have any frozen embryos currently?	
How many children do you want?	

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PARTNERS NAME:	
AGE:	**DOB:** / /
Occupation:	
Have you had a sperm count?	
How many children do you have?	
How many times have you been pregnant with your current partner?	
Do you have any medical conditions?	
Have you had any major surgery?	
Are you on any medications?	
Are you allergic to anything?	
Do you smoke? **YES / NO**	
Are there any illnesses in your family?	
How many children do you want?*	
*(If your answer is different to your partners please discuss this before seeing the doctor!!)	

OFFICE USE ONLY

DIAGNOSIS:

BLOODS:

IMAGING:

SFA:

IVF:

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