| | | |
|---|---|---|
| **PATIENTS NAME:** | | **DATE: / /** |
| **AGE:** | **DOB: / /** | |
| Do you require Donor Services? | Donor Egg | Donor Sperm |
| Do you require Surrogacy Services? | YES | NO |
| Do you have a known chromosomal problem needing specific treatment? | | |
| 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? | | |

| | |
|---|---|
| **PARTNERS NAME:** | |
| **AGE:** | **DOB: / /** |
| Do you have a known chromosomal problem needing specific treatment? | |
| 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:*