Patient History Form

This information will remain confidential at all times

VPS Couple Label

Female name:	DOB: / /
	Age:

MEDICAL HISTORY

Do you have or have you suffered from any of the following?

- ☐ Acne
- ☐ AIDS / HIV positive
- ☐ Anaphylaxis
- ☐ Anaemia
- ☐ Asthma
- ☐ Bleed between cycles
- ☐ Blood disease
- ☐ Breathing problems
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pains
- ☐ Clotting disorders
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Depression / Anxiety
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Excessive body hair
- ☐ Fainting spells / dizziness
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Headaches / migraines
- ☐ Heart disease / problems
- ☐ Heavy periods
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis c
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hives or rash
- ☐ Hypoglycaemia
- ☐ Kidney problems
- ☐ Leaking breasts
- ☐ Leukaemia
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Painful periods
- ☐ Pelvic infection
- ☐ Polycystic ovaries
- ☐ Psychiatric care / illness
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Sexually transmitted diseas
- ☐ Sickle cell disease
- ☐ Spina bifida
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tumours or growths
- ☐
- ☐
- ☐
- ☐

Have you had any serious illnesses or infections not listed above? Yes / No If yes, please explain below:

When did you start trying to conceive a baby with your current partner?				..... Month	..... Year
How old were you when you had your first menstrual period?				Age: …….....	
Are your cycles regular?				Yes	No
How many days from the start of one period to the start of the next period?				..... days	
How many days does your period last for?				..... days	
Have you ever taken the oral contraceptive pill?				Yes	No
Did you experience any problems with the oral contraceptive pill?			n/a	Yes	No
How often do you have sexual intercourse?	Daily	Weekly	Monthly	Only during ovulation	Other
Do you experience any problems or pain with sexual intercourse?				Yes	No

Current weight ..... kg	Height ..... cm	BMI	Blood Pressure ...../.....

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	Age:

PREGNANCIES

Please detail all previous pregnancies, if applicable

Date	Natural conception or IVF	This Relationship or Previous Relationship	Live Birth Y/N	Miscarriage Termination Ectopic	Weeks Pregnant	Vaginal delivery C / Section D & C	Male or Female baby	Any complications? Any abnormalities? Comments

Nurse Co-ordinator to complete: Gravida _____ Para _____ (M _____ T _____ E _____)

Does either partner have an extended family history of any person born with an abnormality?	Yes	No
If yes, please provide details:		

PREVIOUS IVF TREATMENT(S)

Please provide the following details for any previous IVF cycles

Month & Year	Name of IVF clinic	IVF or ICSI	FSH daily dose	Number of eggs collected	Number of ICSI or Number of IVF	Number of eggs fertilised	How many embryos transferred	Number of embryos frozen	Positive or Negative Outcome

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	Age:

SURGICAL HISTORY

Have you had a hysterosalpingogram (HSG) to check if your fallopian tubes are open? Yes / No

Date				
	Is your Left fallopian tube patent (open)?	Yes	No	n/a
	Is your Right fallopian tube patent (open)?	Yes	No	n/a

Please provide details of all operations and procedures

Date	Procedure	Surgeon / Hospital

MEDICATIONS

Please provide details of all current medications (including any homeopathic medications and vitamins)

Name of medication	Dose of medication	How often do you take it?

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VPS Couple Label

Female name:	DOB: / /
	Age:

ALLERGIES

Please provide details of any allergies (including sensitivity to Latex)

Do you have any allergies at all?	Yes	No

If you have an allergy, what are you allergic to, describe your body's reaction and how you treat it?

Allergic to:	What is your body's reaction?	How do you treat this?

PRE-TREATMENT CHECK

Your IVF nurse co-ordinator will discuss the following with you at the time of your initial appointment

<u>You must have a current Pap Smear</u> (please bring copy of result to your 1st appointment)		Dated / /	
Have you ever had an abnormal Pap Smear?	No	Yes	Treatment:
Do you do regular self-breast examinations?	Yes	No	Advised by: .....
Are you a recent smoker?	No	Yes	..... / day
What is your standard alcoholic consumption?		..... / day	..... / week
What is your caffeine consumption? (including coffee, coke, energy drinks)	……..... / day	..... / week	Advised by: .....
Do you currently use any recreational drugs?	No	Yes	.....
Are you currently taking Folic Acid?	Yes	No	Advised by: .....
Do you have a current referral from your GP?	Yes	No	Date requested: .....

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VPS Couple Label

Female name:	DOB: / /
_____	Age:

FEMALE PRECONCEPTION SCREENING OPTION

There is an optional preconception screening test available. A Doctor will discuss this with you during your consultation. Please indicate below if you wish to have this test done at a cost to the patient of **$285.** (Cost current at time of publishing but subject to change)

Cystic Fibrosis (CF) Screening (costs apply)	No	Yes

OFFICE USE ONLY:
STANDARD SCREENING TESTS (Bulk Billed to eligible patients)

Test required	Date Collected	By: (Initials)	Result received & attached	By: (Initials)	Dr has reviewed result (Nurse initials)
☐ FSH					
☐ LH					
☐ E2					
☐ PROG					
☐ TFT's					
☐ AMH					
☐ PROL					
☐ TESTO					
☐ HIV Ab					
☐ Hep Bs Ag					
☐ Hep C Ab					
☐ TPPA					
☐ Karyotype					
☐ VZV IgG					
☐ RUB IgG					
☐ U Chlamydia					
☐ Blood Group					
☐ Pap Smear					

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VPS Couple Label

Male name:	DOB: / /
	Age:

MEDICAL HISTORY

Do you have or have you suffered from any of the following?

☐ AIDS / HIV positive	☐ Epilepsy or seizures	☐ Infection in testes	☐ Radiation treatment
☐ Anaphylaxis	☐ Genital herpes	☐ Lump in testes	☐ Sexually transmitted diseas
☐ Asthma	☐ Heart disease / problems	☐ Mumps	☐ Sickle cell disease
☐ Blood disease	☐ Hepatitis A	☐ Pain in testes	☐ Spina bifida
☐ Cancer	☐ Hepatitis B	☐ Pain passing urine	☐ Trauma to testes
☐ Chemotherapy	☐ Hepatitis C	☐ Pain during sex	☐ Vasectomy
☐ Cystic fibrosis	☐ Hernia	☐ Problems with ejaculation	☐ Vasectomy reversal
☐ Diabetes	☐ Herpes	☐ Problems with erection	☐ Undescended testes
☐ Drug addiction	☐ High blood pressure	☐ Problems with orgasm	☐
☐ Depression / Anxiety	☐ High cholesterol	☐ Psychiatric care / illness	☐

Have you had any serious illnesses or infections not listed above? Yes / No If yes, please explain below:

Are you aware of any previous pregnancies that you have conceived?		Yes	No
Do you have children from a previous relationship?		Yes	No
Have you ever had a semen analysis performed?	Date tested:	Yes	No
If yes, where was your semen analysis performed and was it normal?	Lab used to Test:	Yes	No
Have you ever used anabolic steroids?		Yes	No

SURGICAL HISTORY

Please provide details of all operations and procedures

Date	Procedure	Surgeon / Hospital

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VPS Couple Label

Male name:	DOB: / /
	Age:

MEDICATIONS

Please provide details of all current medications (including any homeopathic medications and vitamins)

Name of medication	Dose of medication	How often do you take it?

ALLERGIES

Please provide details of any allergies

Do you have any allergies at all?	Yes	No

If you have an allergy, what are you allergic to, describe your body's reaction and how you treat it?

Allergic to:	What is your body's reaction?	How do you treat this?

PRE-TREATMENT CHECK

Your IVF nurse co-ordinator will discuss the following with you at the time of your initial appointment

Are you a recent smoker?	No	Yes	..... / day
What is your standard alcoholic consumption?		..... / day	..... / week
What is your caffeine consumption? (including coffee, coke, energy drinks)	..... / day	..... / week	Advised by: .....
Do you currently use any recreational drugs?			.....
Do you have a current referral from your GP?	No	Yes	Date requested: .....

Weight ..... kgs	Height ..... cm	BMI .....

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VPS Couple Label

Male name:	DOB: / /
	Age:

MALE PRECONCEPTION SCREENING OPTION

There is an optional preconception screening test available. A Doctor will discuss this with you during your consultation. Please indicate below if you wish to have this test done at a cost to the patient of **$285** (Cost current at time of publishing but subject to change).

Cystic Fibrosis (CF) Screening (costs apply)	No	Yes

OFFICE USE ONLY:
STANDARD SCREENING TESTS (Bulk Billed to eligible patients)

Test required	Date Collected	By: (Initials)	Result received & attached	By: (Initials)	Dr has reviewed result (Nurse initials)
☐ Semen Analysis					
☐ FSH					
☐ LH					
☐ TFT's					
☐ HIV Ab					
☐ Hep Bs Ag					
☐ Hep C Ab					
☐ Syphilis					
☐ Chromosomes					

Has medical history and relevant documentation been entered into VPS?	Yes	No	Reason:

Additional Nursing or Clinician notes:

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VPS Couple Label

Female name:	DOB: / /
Male name:	DOB: / /

PATIENT DECLARATION:

- I/we have been informed of The Fertility Centre fees and charges and accept full responsibility for these costs.
- I/we understand that the Medicare reimbursement discussed is subject to variation depending on our individual situation.
- I/we confirm that we have been advised that we may incur additional non TFC costs and understand we will be responsible for the payment of these.
- I/we acknowledge we have been provided with written estimates of the costs associated with treatment at The Fertility Centre. Costs associated with Embryo/Oocyte Freezing are additional to standard charges.
- I/we consent to the collection of blood and urine samples for pathology testing and understand that it is essential that I/we return to The Fertility Centre to see a Doctor to discuss the results.

Female partner:	SIGNATURE	Date / /
Male partner:	SIGNATURE	Date / /
IVF Nurse co-ordinator:	SIGNATURE	Date / /
Medical histories reviewed by Doctor:	SIGNATURE	Date / /