Medical History Form

Date of Issue: 22 July 2015

Female Information			
Patient Name		Date of Birth	
Address		Medicare number	
		Concession No.	
Mobile			
Email			

Medical History			Further Details
Weight		kg	
Height		cm	
BMI			
Blood Pressure (BP)	Manual/Auto		
Thyroid problems	No	Yes	
Treatment for cancer	No	Yes	
Diabetes	No	Yes	
High blood pressure	No	Yes	
Respiratory Disease/Asthma	No	Yes	
Pelvic infection (tubes /ovaries)	No	Yes	
Sexually transmitted disease	No	Yes	
Bleeding or clotting disorders	No	Yes	
Heart Disease or Rheumatic Fever	No	Yes	
Mental Health/Anxiety/Depression	No	Yes	
Any other illnesses or infections?			
Smoker	No	Yes	Average cigarettes p/week
Alcohol intake	No	Yes	Average weekly intake
Recreational drugs use	No	Yes	Drug/Frequency
Current Medications			
Natural Medicine or Supplements			
Pre-conception vitamin or folic acid			
Allergies eg: Latex, Iodine, Medications, Tapes, Foods			

Surgical History *Please give details of any operations or procedures*.		
Date	Procedure	Hospital/Surgeon

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Fertility History						
Duration of trying to conceive for a baby with current partner?			Previous partner?			
Age at start of menstrual period		years	Pain with periods		No	Yes
Regularity of cycle		days	Bleeding/spotting between cycles		No	Yes
Length of bleeding		days	Heavy periods		No	Yes
Regularity of Sexual Intercourse						
Any problems or pain?						
Any history of endometriosis?						
Any testing of tubal patency?						
Have you taken the contraceptive pill?	No	Yes	Any problems taking pill?		No	Yes
Comments						
Last Pap Smear	Date		Normal	Abnormal	Unsure	

Details of any previous Pregnancies							
Date	Current (C) or previous (P) partner	Live birth (Yes/ No)	Miscarriage/ termination ectopic	No. of weeks pregnant	Mode of delivery	Male/ Female	Delivery complications/ comments
Is there a family history of any children born with an abnormality?							

Previous Infertility Treatment							
Month/Year	Clinic location	Protocol/ cycle type	FSH daily dose	Total number of eggs collected	No. of embryos created	Frozen embryo transfer	Outcome / comments

Female patient signature		Date	

Clinic Notes

Medical History Form

Date of Issue: 22 July 2015

Male Information			
Patient Name		Date of Birth	
Address		Medicare number	
		Concession No.	
Mobile			
Email			

Medical History			Further Details
Diabetes	No	Yes	
High blood pressure	No	Yes	
Sexually transmitted disease	No	Yes	
Heart Disease or Rheumatic Fever	No	Yes	
Mumps	No	Yes	
Hernia / Corrected surgically	No	Yes	
Treatment for cancer, Surgery or Radiation	No	Yes	
Mental Health/Anxiety/Depression	No	Yes	
Any other illnesses or infections?			
Smoker	No	Yes	Average cigarettes p/week
Alcohol intake	No	Yes	Average weekly intake
Recreational drugs use	No	Yes	Drug/Frequency
Current Medications			
Natural Medicine or Supplements			
Allergies - Latex, Iodine, Medications, Tapes ,Foods			

Surgical History *Please give details of any operations or procedures*.		
Date	**Procedure**	**Hospital/Surgeon**

Fertility History			Further Information		
Do you have any children from previous relationships?					
Did you have fertility treatment with your previous partner?					
Is there a family history of any children born with an abnormality?					
Undescended Testes / Corrected surgically	No	Yes			
Problems with erection, ejaculation or orgasm	No	Yes			
Infection or Trauma to testes	No	Yes			
Pain in testes, passing urine or during sex	No	Yes			
Vasectomy / Vasectomy reversal	No	Yes			
Have you had a semen analysis performed?	No	Yes	Where		
Semen Analysis results Date		Normal	Abnormal	Unsure	
Please list abnormalities detected					

Male partner signature		**Date**	

Clinic Notes