Melbourne IVF

By answering the following information as accurately as possible, you help us get a better understanding of the problems that may influence your fertility. Take your time and read all the questions carefully. Please give the completed questionnaire to reception staff.

Female: Surname_____ Given Name_____ DOB_____

Partner: Surname_____ Given Name_____ DOB_____
Male ❑ Female ❑ (please tick)

SPECIFIC QUESTIONS FOR THE FEMALE PARTNER

Have you ever been pregnant? YES / NO If **YES**, when was your last pregnancy?_____

If **YES**, please specify how many pregnancies you have had in this table:

	Current Partner	Previous Partner (s)
Miscarriages		
Terminations of Pregnancy		
Ectopic Pregnancies (e.g. in the tube)		
Live Births		

If you are trying to get pregnant, how many months have you been trying for?_____

Have you ever received any fertility treatment? YES / NO

If **YES**, please specify:_____

Please list previous forms of contraception (if any)_____

How old were you when you had your first period?_____

On average, how long is your cycle? (from the 1st day of your period until the 1st day of your next period)_____to_____days.

On average, how many days does your period last? (from the 1st day until the last day of your period)_____days

Is your period painful? YES / NO

Do you feel that the amount of blood loss is abnormal? YES / NO

Do you have a lot of symptoms prior to your period? YES / NO

Is there vaginal blood loss between your periods? YES / NO

Is intercourse painful? YES / NO

Have you been diagnosed with Endometriosis? YES / NO

Do you or your GP think you have Endometriosis? YES / NO

When was your last Pap Smear?_____

Was it normal? YES / NO

Have you ever had any pelvic infection, STI or Chlamydia? YES / NO

Do you have pain passing a bowel motion? YES / NO

Have you ever had an operation?	YES	/	NO
If **YES**, have you ever had a:			
caesarean section?	YES	/	NO
operation on the cervix?	YES	/	NO
laparoscopy (telescope through the belly button)?	YES	/	NO
gynaecological operation via abdominal incision?	YES	/	NO
operation on the bowel?	YES	/	NO
have you ever been treated for the following illnesses?			
diabetes	YES	/	NO
thyroid disease	YES	/	NO
tuberculosis	YES	/	NO
Have you ever been hospitalized for an illness?	YES	/	NO

If **YES**, please specify:_____

Are you currently under any form of treatment?	YES	/	NO

If **YES**, please specify:_____

Do you have any diseases that run in the family?	YES	/	NO

If **YES**, please specify:_____

Are you on any regular medication?	YES	/	NO

If **YES**, please list:_____

Do you have any allergies? (medication, food… etc)	YES	/	NO

If **YES**, please list:_____

Signature:_____ **Date:**_____

Melbourne IVF

Female: Surname_____ Given Name_____ DOB_____

Male: Surname_____ Given Name_____ DOB_____

SPECIFIC QUESTIONS FOR THE MALE PARTNER

(If the reason for seeing Dr Pearce is difficulty getting pregnant/Infertility/IVF)

Lifestyle: Weight (kg)_____ Height (cm)_____

Have you lost or gained a lot of weight recently?	YES	/	NO	
Do you smoke?	YES	/	NO	How many cigarettes per day?_____
Do you drink alcohol?	REGULARLY / RARELY / NEVER			
Do you come into contact with harmful substances in your workplace?	YES	/	NO	
Have you ever had one of the following illnesses?				
Diabetes	YES	/	NO	
Thyroid Disease	YES	/	NO	
Liver or Kidney Disease	YES	/	NO	
Chronic Lung Disease	YES	/	NO	
Do you know of people in your family who have an inherited condition?	YES	/	NO	

If **YES**, what?_____

Have you ever had an operation?	YES	/	NO	
If **YES**, have you ever had:				
operation on one / both testicles?	YES	/	NO	
vasectomy?	YES	/	NO	
operation on your bladder?	YES	/	NO	
prostate operation?	YES	/	NO	
operation on your penis?	YES	/	NO	
inguinal hernia repair?	YES	/	NO	
operation on your spinal cord?	YES	/	NO	
Have you ever had mumps?	YES	/	NO	If **YES**, at what age?_____
Have you ever experienced severe pain in one / both testicles?	YES	/	NO	
Have you ever been treated for undescended testes?	YES	/	NO	
Have you ever been treated for a urinary infection?	YES	/	NO	
Have you ever had problems with erection / ejaculation?	YES	/	NO	
If you have had other partners, was one of them ever pregnant?	YES	/	NO	
Are you on any regular medication?	YES	/	NO	Please list_____

Do you have any allergies (medication, food…etc)?_____

Signature:_____ **Date:**_____