



Please complete this form and bring to your appointment. Prepare a list of questions you might wish to ask the doctor. All information provided will be treated as strictly confidential.

Please circle the correct answer. (Example: Are your periods painful? Yes/  No )

	<b>Female</b>	<b>Partner</b>
<b>1. Surname</b>	_____	_____
<b>2. First name</b>	_____	_____
<b>3. Date of birth</b>	_____ Age _____	_____ Age _____
<b>4. Marital status</b>	_____	_____
<b>5. Maiden/Previous Names</b>	_____	_____
<b>6. Occupation</b>	_____	_____
<b>7. Telephone no. (Home)</b>	_____	_____
<b>Telephone no. (Cell)</b>	_____	_____
<b>8. Telephone no. (Work)</b>	_____	_____
	Can we call you at work? Y/N	Can we call you at work? Y/N
<b>9. Medicare number:</b>	_____	_____
	Expiry date: _____	Expiry date: _____
<b>10.</b>	<b>Address in Canada:</b>	<b>Foreign Address:</b>
<b>Street:</b>	_____	_____
<b>City:</b>	_____	_____ Country:
<b>Postal code:</b>	_____	_____
<b>E-mail address</b>	_____	
<b>11. Referring doctor:</b>	General Practitioner/Gynecologist/Other specialist/Self-referral	
<b>Name:</b>	_____	Telephone no. _____
<b>Address:</b>	_____	

## Female Partner

Today's Date: \_\_\_\_\_ Your Height: \_\_\_\_\_ Your Weight: \_\_\_\_\_

**M / D / Year**

### Menstrual History:

12. Age when periods first started \_\_\_\_\_ years
13. How often do your periods come ? \_\_\_\_\_ / \_\_\_\_\_ days.  
average / range  
*(Example - average 28 days / range 26-30 days)*
14. How many days does your period last ? \_\_\_\_\_ days
15. Are your periods painful ? **Yes / No**  
 If yes, which day(s) of the menstrual cycle? (1st day of your cycle is the 1st day you bleed)  
 \_\_\_\_\_
16. When did your last period start? \_\_\_\_\_

### 17. Previous Pregnancies:

Year	Current Partner (Yes/No)	Number of weeks that you were pregnant	Miscarriage (Yes/No)	Abortion (Yes/No)	Live Birth (Yes/No)	Birthweight	Complications, e.g. Cesarean, infection, etc.

### 18. Contraception:

Years used

Pill Y/N \_\_\_\_\_ Brand \_\_\_\_\_

Intrauterine device Y/N \_\_\_\_\_ Type \_\_\_\_\_

Other : \_\_\_\_\_ Sterilization Y/N

### Gynecological History

19. Please **circle** if you have had a history of:

Sexually transmitted disease / Pelvic inflammatory disease / Gonorrhea / Chlamydia

Surgery on your tube / ovary / uterus / Removal of your appendix / Laparoscopy / Hysteroscopy /

Surgery on your cervix/ LEEP / Any other abdominal or pelvic surgeries;

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20. Date of last PAP test \_\_\_\_\_
21. Was it normal ? **Yes / No**
22. Have you ever had an abnormal result **Yes / No**  
If yes give dates and treatment: \_\_\_\_\_

**Sexual History**

23. On average, how often do you have sexual intercourse? \_\_\_\_\_ **per week**

**General Health:**

- 24 Is your weight stable / increasing / decreasing ?
25. Have you had any serious illnesses in the past ? **Yes / No**  
If so, please give details:  
\_\_\_\_\_
26. Have you ever tested positive for Hepatitis B, Hepatitis C, Syphilis or HIV **Yes / No**
27. Have you ever had a discharge from your nipples ? **Yes / No**
28. Do you have a problem with body/facial hair or acne? **Yes / No**  
*If Yes for how many years have you had this problem? \_\_\_\_\_*
29. Are you on any medications? Vitamins? Folic Acid? If yes, please give names and dosages: **Yes / No**  
\_\_\_\_\_  
\_\_\_\_\_

30. Do you have any allergies ? If yes, please give details: **Yes / No**  
\_\_\_\_\_  
\_\_\_\_\_

31. How many cigarettes do you smoke? (enter 0 if non-smoker) \_\_\_\_\_ **per week**

32. How many glasses of alcohol do you drink? \_\_\_\_\_ **per week**

33. Do you have any conditions or serious illnesses that run in your family? For example cystic fibrosis, diabetes, hypertension, obesity, thyroid abnormalities, endometriosis, fibroids, cancers or autism. **Yes / No**  
If yes, please give details:  
\_\_\_\_\_  
\_\_\_\_\_

**Infertility History:**

34. How many years have you been trying to conceive as a couple? \_\_\_\_\_ **years**

35. Have you had any previous infertility investigations? **Yes / No**

If YES please give details and please GIVE A COPY OF YOUR RECORDS TO THE RECEPTIONIST

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36. Please complete this table if you ever had In-Vitro Fertilization (*test-tube treatment*)

	Cycle 1	Cycle 2	Cycle 3	Cycle 4	Cycle 5
Year					
Doctor					
Centre					
Eggs obtained					
Eggs fertilized					
ICSI (Y/N)					
Number of Embryos transferred					
Number of Embryos Frozen					
Husband/Donor					
Pregnancy (y/n)					
Complications (y/n)					

37. Please complete this table if you ever had other fertility treatments such as oral or injectable medications to stimulate your ovaries combined with intrauterine insemination:

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5
Year					
Doctor					
Centre					
Clomid (Y/N)					
Gonadotropins (Y/N)					
Intrauterine insemination (Y/N)					
Husband/Donor					
Pregnancy (Y/N)					
Complications (Y/N)					

## **Male Partner (if applicable)**

38. Have you ever had

Undescended testis / Surgery to bring down testicle / Surgery for hernia / Surgery for prostate enlargement / Surgery for torsion of testicle / Hypospadias (*urethral opening on the underside of the penis*) / Accident involving your genitalia / Discharge needing treatment/ Diagnosed sexually transmitted disease / Inflammation of testicle or epididymis / Mumps (as an adult / Cystoscopy / Scrotal *surgery (surgery to your testicle)* / Vasectomy / Previous radiotherapy / Previous chemotherapy

If you had any of above please give details:

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39. Do you have any children from previous relations ? **Yes / No**

If yes - how many ? \_\_\_\_\_

40. Do you have any problems with sexual intercourse? **Yes / No**

41. Are you able to produce a semen sample by masturbation ? **Yes / No**

42. Previous infertility investigations and treatment? **Yes / No**

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43. Have you had any serious illnesses in the past? **Yes/No**

If yes, please give details:

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44. Have you ever tested positive for Hepatitis B, Hepatitis C, Syphilis or HIV **Yes / No**

45. Are you on any long term medications ? If yes, please give names and dosages: **Yes/No**

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46. Do you have any illnesses or conditions which run in your family? **Yes/No**

(for example cystic fibrosis, infertility, autism, etc.)

If yes, please give details:

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47. Do you have any allergies? If yes, please give details: **Yes/No**

48. How many cigarettes do you smoke? (enter 0 if non-smoker) \_\_\_\_\_ **Per Week**

49. How many glasses of alcohol do you drink? \_\_\_\_\_ **Per Week**

## **Couple's Social Concerns (Optional)**

50. Apart from your infertility, are you under stress (personal, professional, financial)

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51. What is usually most helpful to you when you are under stress?

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52. Who are your key support persons?

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53. How has your infertility affected your relationship with family and friends?

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54. How has your infertility affected your marriage?

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55. How has your infertility affected your feelings about yourself?

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56. What are your expectations about therapy?

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57. Do you have any therapy related concerns?

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58. Are you keeping your therapy secret from family, friends, and/or co-workers?

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59. Do you have any religious considerations that may affect your treatment?

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**Important: At your first consultation please bring with you photocopies of all previous investigations and infertility treatment for both of you.**



**Date** \_\_\_\_\_

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**Date** \_\_\_\_\_

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**Date** \_\_\_\_\_

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**Date** \_\_\_\_\_

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