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))

	Female	Partner
1. Surname	_____	_____
2. First name	_____	_____
3. Date of birth	_____Age_____	_____Age_____
4. Marital status	_____	_____
5. Maiden/Previous Names	_____	_____
6. Occupation	_____	_____
7. Telephone no. (Home)	_____	_____
Telephone no. (Cell)	_____	_____
8. Telephone no. (Work)	_____ Can we call you at work? Y/N	_____ Can we call you at work? Y/N
9. Medicare number:	_____ Expiry date: _____	_____ Expiry date: _____
10.	**Address in Canada:**	**Foreign Address:**
Street:	_____	_____
City:	_____	_____Country:
Postal code:	_____	_____
E-mail address	_____	

11. Referring doctor: General Practitioner/Gynecologist/Other specialist/Self-referral

Name: _____ Telephone no._____

Address: _____

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;

_____

_____

_____

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

_____

_____

_____

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 epidydimis / Mumps (as an adult / Cystoscopy / Scrotal *surgery (surgery to your testicule)* / Vasectomy / Previous radiotherapy / Previous chemotherapy

If you had any of above please give details:

_____

_____

_____

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**

_____

_____

_____

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

If yes, please give details:

_____

_____

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**

_____

_____

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:

_____

_____

_____

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)

_____

_____

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

_____

52. Who are your key support persons?

_____

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

_____

54. How has your infertility affected your marriage?

_____

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

_____

56. What are your expectations about therapy?

_____

57. Do you have any therapy related concerns?

_____

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

_____

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

_____

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

To be completed by physician **Date_____**

Summary:

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Date_____

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Date_____

Date_____

Date_____

Date_____