FertilityNorth
Fertility & Endometriosis Treatment Centre
GynaeNorth

MEDICAL INFORMATION

Please disregard MALE PARTNER section of this form if you are a single woman or a same sex couple

Female Patient Details
AFFIX LABEL HERE to be initialled by patient Patient Initial……

Patient Partner Details
AFFIX LABEL HERE to be initialled by patient's partner Partner Initial……

Height (cm)		Weight (kg)		BMI	
Ethnicity					
Occupation					

Height (cm)		Weight (kg)		BMI	
Ethnicity					
Occupation					

PART I - FEMALE PATIENT INFERTILITY HISTORY

When did you and your partner start trying to conceive?	Month: _____ / Year:_____
During that time have you lived apart or avoided pregnancy? (circle)	Yes (Duration: _____) / No
Do you or your partner work FIFO?	Yes (Usual Roster: _____on/_____off / No

Have you experienced any of the following? (tick all that apply)			
Irregular/ Infrequent Periods	☐	Milky breast discharge	☐
Excessive / Abnormal hair growth	☐	Poor sense of smell	☐
Bad skin/ acne	☐	Visual disturbance	☐

Have you been investigated or treated for Infertility before?	No ☐ *(move on to Part II)* Yes ☐ *(complete sections below)*

PREVIOUS CLINIC(S)

Clinic Name	Date first seen	Date last seen	Specialist name
1.			
2.			
3.			

PREVIOUS TREATMENT CYCLE(S) ***(Please bring any results / reports you have to your consultation and complete details below)***

Type of Cycle	Outcome	Clinic Name	Date
1.			
2.			
3.			
4.			
5.			

PART II – FEMALE PATIENT OBSTETRIC / GYNAECOLOGICAL HISTORY

MENSTRUAL HISTORY			
Age of first ever period?		Date of first day of last period?	

IN THE LAST 6 MONTHS			
Average number of days from 1st day of period to the 1st day of next period days?			
Average number of days of bleeding?			
Flow (circle)	Light / "Normal" / Heavy	Pain (circle)	Mild-None / Moderate / Severe
Do you have bleeding between periods? (circle)	Yes / No	Describe	

CONTRACEPTION		
Type(s) of Contraception used in the past	Approximate Start Date	Approximate Date of Last Use
1.		
2.		
3.		

INTERCOURSE ☐ N/A			
Is Intercourse painful? (circle)	Yes / No	Describe	
How often have you had intercourse in the last 6 months?			_____ times per Month / Week (circle)
Do you try to identify your most fertile time of the month? (circle)	Yes / No	Describe	

PREVIOUS GYNAECOLOGICAL SURGERY			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

Have you ever been diagnosed with an STI? (circle)	Yes / No	Describe	
Date of last pap smear / cervical screening test (CST):		Result?	
Have you ever had any abnormal pap / CST results? (circle)	Yes / No	Describe	

PREGNANCIES				
Pregnancies	Month / Year	Outcome*	Duration (w)	Previous Partner (Y / N)
1st				
2nd				
3rd				
4th				
5th				

* V= Vaginal birth, C/S=Caesarean birth, M1= Complete Miscarriage, M2= Miscarriage needing curette, E= Ectopic pregnancy, T= Termination of pregnancy

PART III – FEMALE PATIENT MEDICAL & FAMILY HISTORY

MEDICINES	
List Allergies to Medicines	List Prescribed Medications
1.	1.
2.	2.
3.	3.
4.	4.

Do you use complimentary medicines? (circle)	Yes / No	Describe	

List any medical problems you have EVER had in your ENTIRE life to date (not already mentioned)			
Condition	Treatment	Resolved (Yes / No)	Date (month/year)
1.			
2.			
3.			
4.			

OPERATION(S)			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

List any diseases or genetic conditions that have affected your family E.g. diabetes, endometriosis, gynaecological cancer, blood disorder, spina bifida, congenital heart disease			
Condition	Who is affected	Age at onset	Date (month/year)
1.			
2.			
3.			
4.			

PART IV - MALE PARTNER INFERTILITY HISTORY ☐ N/A

Have you had any pregnancies with previous partners?			Yes (number of pregnancies_____) / No
Have you had a history of infertility with a previous partner? (circle)	Yes / No	Describe	
Have you had any trauma to the genitals area? (circle)	Yes / No	Describe	

PREVIOUS UROLOGICAL / GROIN SURGERY (if applicable)			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

Have you been ever diagnosed with an STI? (circle)	Yes / No	Describe	
Have you ever had a semen analysis? (circle)	Yes / No	If yes, please bring a copy of the report to your consultation.	
Do you ever have any erectile or ejaculatory difficulties? (circle)	Yes / No	Describe	

PART V – MALE PARTNER MEDICAL & FAMILY HISTORY ☐ N/A

MEDICINES	
List Allergies to Medicines	List Prescribed Medications
1.	1.
2.	2.
3.	3.
4.	4.

Do you use complimentary medicines? (circle)	Yes / No	Describe	

List any medical problems you have EVER had in your ENTIRE life to date (not already mentioned)			
Condition	Treatment	Resolved (Yes / No)	Date (month/year)
1.			
2.			
3.			
4.			

OPERATION(S)			
Type of Operation	Surgeon	Location	Date
1.			
2.			
3.			

List any diseases or genetic conditions that have affected your family **E.g.** diabetes, endometriosis, gynaecological cancer, blood disorder, spina bifida, congenital heart disease			
Condition	Who is affected	Age at onset	Date (month/year)
1.			
2.			
3.			
4.			

PART VI – LIFESTYLE

HOW MUCH DO YOU?	FEMALE PATIENT	PATIENT PARTNER
Smoke? (per day)		
Drink Coffee? (cups per day)		
Drink Alcohol (drinks per week)		
Exercise? (times per week)		
Take Folate? (times per day)		N/A
Take Vitamin Supplements? (times per week)		
Use Non-prescription drugs?	Yes / No	Yes / No

Is there anything else not covered that you or your partner feels may be relevant?