REGISTRATION FORM

Female

First Name…… Last Name……..

Home Address…… Work Address…….

Ph.No…….. Ph.No……..

E-mail address……..

May we e-mail documents to you ……. Yes/No

Occupation ……..

Referred by : Dr…… Dr contact……..

Number/email……..

Date

Can we contact you after sometime to enquire about your feedback on this

consultation …… Yes/No/Maybe

FEMALE MEDICAL HISTORY

Age:……..Yrs. HT: ..... CMS WT…….Kg BMI…….

Is your Weight Steady increasing & decreasing?.....

How long you have been married?.....

How long you been trying to become pregnant? ……..

Any known reasons for Infertility: Unsure / any of the below.

Not fully tested yet ☐ Unexplained ☐

Male:

Testicular Failure ☐ Poor Quality Sperm ☐

NO Sperm ☐ Unable to release Sperm ☐

Female:

Ovarian Failure ☐ Poor Quality Eggs ☐

Low number of Eggs ☐ No release of Eggs ☐

PCO ☐ Thin uterine lining ☐

Fibroids ☐ Endometriosis ☐

Tubes blocked/damaged/removed: ☐ both /left/right

Previous Pregnancies

Have you ever been pregnant before? Yes/No If yes, is it in current relationship? Yes/No

Details:

Month & Year/Hospital	Type of conception Natural/IUI//IVF	Outcome Live birth, Stillbirth, Miscarriages, Ectopic, Termination (medical/surgical), Antenatal. Problems:Diabetes,high Bp,bleeding,preterm,difficult delivery,post-natal problems	No of weeks gestation	Sex and health of the baby

Gynecological History

- Age at first period?.....yrs. Last menstrual Period Started:……/……./……..
- Are your periods regular / Irregular
- How many days you bleed..... Cycle Interval.....Days
- Shortest gap……..Days Longest gap…….Days
- Do you bleed / spot before and or after period?
  Yes/No
  - Between the cycles. Yes/No
  - After the Intercourse Yes/No
- How often you have intercourse? 0/1-3/ >3… Weekly/Monthly
- Lack of interest in sex Yes/No
- Do you have any problem with intercourse?
  Yes/No
- Interested in sex but unable to have intercourse Yes/No
- Painful sex
  Yes/No
- Have you had any Cervical Smear test before? Yes/No
  - Last smear date:……. Normal / Abnormal
- Have you had history of:
  - Vaginal discharge requiring treatment Yes/No
  - Sexually-transmitted disease? Yes/No
  - Pelvic inflammatory disease, Gonorrhea,
    Chlamydia Yes/No

  Fibroid/Cyst/Endometriosis/Ectopic Yes/No

  ……

5. Tuberculosis-/chest X Ray/Montoux Test or other Yes/No
6. Any other abdominal operations? Yes/No

   (If 'Yes' please give details)…….

- Laparoscopy/hysteroscopy.... Yes/No

  Details
  Records
  Images/videos
  (PLEASE REMEMBER TO BRING ALL previous records)
- Does a discharge ever come from your nipples? Yes/No
- Do you have immunity to Rubella? Yes/No
- Sickle cell/Thalassemia status-negative/trait
  /not at risk/at risk.. Yes/No

Pervious Fertility Treatment(s): YES / NO

Ovulation Inductions (0I): YES/NO

Number of attempts……..

Date/yr	Hospital	OI + TI	Stimulation drugs/dose	No. follicles	trigger	Luteal sup.	Outcome/ Comment

0I with Artificial Insemination: YES / NO

Number of attempts...

Date/Year	Hospital		Stimulation drugs/dose	No. follicles	trigger	Luteal sup.	Outcome/ Comment

IVF/ICSI : YES/NO

Date year	IVF/ICSI SPLIT	Hospital	Stimulation drugs/dose	Duration	Total eggs	No. Fertilized	No. Transfer	No Frozen	Outcome/ Comment

Social History

Do you smoke? Yes/No

If Yes, How many per day?.....

- Have you ever used any recreational drug in the last 3 months? if yes, what and when?..... Yes/No

- Do you drink alcohol?..... Yes/No
  Alcohol units per week?..... Yes/No
  (1 unit is a standard glass of wine, half a pint of beer or a single measure of spirits)

Medical History.

Do you or your family member/Relatives have the following;

Condition	Yourself Yes/No	Your relative Yes/No	Comments
Diabetes			
Blood Pressure			
Thyroid defects			
Asthma/Allergies			
Tuberculosis			
Birth defects/inherited conditions			
Epilepsy			
Rheumatoid arthritis			
Cancer			
Crohn's disease			
Thalassemia			
Other Infertility/Miscarriages			

Surgical History

Have you had any Major Operations Abdomen/Pelvis/Chest/Heart/Spine/Bones — Yes/No

Have you had any operations for fibroid/Polyp/Ovarian Cyst/ Endometriosis/Adhesions (If Yes to either, please give details in the table below.) — Yes/No

Hospital	Year/Date	Details of Operations

CONTRACEPTION

Are you Using any of Contraception now — Yes/No

Did you ever use any contraceptive — Yes/No

-If yes,

Contraceptive pill ☐ — Yes/No

Years…….

IUCD (intrauterine contraceptive device) ☐ No. of Years…….. — Yes/No

Others ☐ No. of Years…….. — Yes/No

Allergies

- Do you have any sensitivity to drugs/object's Yes/No
- Have you had a reaction to local or general anesthetic Yes/No

Please specify any allergies in the table below:

Allergy to any medication/Latex/Nuts/Eggs/Soya/Milk product/others	Type of reaction

Current Medication

Are you taking any tablets including vitamins or homeopathic/Ayurvedic/other

Yes/No

Have you taken Ayurvedic medicine in last 6 Month Yes/No

If you are on medication, vitamin or homeopathic remedies please complete the following table:

Medication	Dose	Frequency

-Must attach copy of all reports without fail-

Female investigations: Please complete the following test reports if available:

TEST	Result /Date	Result /Date	Result /Date	Result /Date	Result /Date	Comments
AMH						
Progesterone(DAY 21)						
FSH/LH(DAY 2-5)						
HbA1c/Hb						
Estradiol						

Female investigations: Please complete the following test reports if available: (Continued)

TEST	Result /Date	Result /Date	Result /Date	Result /Date	Result /Date	Comments
TSH						
T4						
PRI-						
Rubella						
Chlamydia (igG/ lgM)						
HIV						
Hepatitis B						
Hepatitis C						
HTLV						
Sickle Cell						
HSG/Hycosy/ HYFOSY SCS			RRF Tests: Toxo lgM: CMV lgM			
Thrombophilia Screen						
Karyotype						
RRF Tests+Others	LA	ACA lgG	ACA lgM	AAb Profile	T-Ab	Toxo lgG CMV I M
Others						

I hereby state that the information provided by me are correct to the best of my knowledge, if any Information provided herein need correction on a later date, I would do so without fall as I understand that accuracy of the information provided herein could have a bearing on the treatment rendered and I or envisaged.

Signature & Date