Patient Registration Form

FEMALE PATIENT NAME; ----------

MAIDEN NAME (If Applicable) ----------

FULL POSTAL ADDRESS; ----------

DATE OF BIRTH; ----------

NATIONALITY: ----------

PPS NUMBER; ----------

DPS NUMBER ; (if applicable) ----------

TELEPHONE NO's:

Home: ---------- Ok to leave a message? _____
Work (or 9-5pm): ---------- Ok to leave a message? _____
Mobile: ---------- Ok to leave a message? _____

PERSONAL EMAIL ADDRESS; ----------

OCCUPATION; ----------

KNOWN ALLERGIES: ----------

GP NAME: ----------

GP ADDRESS (Full); ----------

Do you have a medical Referral to Rotunda IVF? _____ Name of referring Doctor: _____

If you were not referred by a doctor, please state how you heard of Rotunda IVF;

FRIEND: ---------- RELATIVE: ----------

NEWSPAPER: ---------- RADIO: ----------

INTERNET: ---------- T.V: ----------

Patient Registration Form

PARTNER'S NAME: ---------- SEX: _____

DATE OF BIRTH: ----------

NATIONALITY: ----------

TELEPHONE NO's:

Home: ---------- Ok to leave a message? _____
Work (or 9-5pm): ---------- Ok to leave a message? _____
Mobile: ---------- Ok to leave a message? _____

PERSONAL EMAIL ADDRESS; ----------

OCCUPATION; ----------

KNOWN ALLERGIES: ----------

GP NAME: ----------

GP ADDRESS; Full Postal Address: ----------

Female Patient Medical History

Patient Registration Form

Please complete this form to the best of your knowledge. If there are any question you are uncertain about, do not worry. The details will be discussed with the doctor at the first appointment. The form will take some time to complete. If you have any questions or queries, please do not hesitate to contact us.

If you have further information, medical records or otherwise, please bring them to the first appointment so that your doctor can review them.

Height: _____ Weight _____

Have you ever undergone an operation? (If so, please give details).
1. _____Year:_____
2. _____Year:_____
3. _____Year:_____

Are you currently on any medications? _____

How long have you been trying to conceive (duration)? _____

Have you used contraception before? _____ (If yes, please describe)
_____ Duration: _____
_____ Duration: _____

Are you currently attending a medical doctor or being treated for an illness or medical condition?
_____
_____

Have you had any illnesses or been treated for a medical condition in the past?
_____
_____

Do you have any general medical complaints at present?
_____
_____

Are you currently using any non-fertility medications?
_____
_____

Have you ever had any problems in any of the following areas?

Endocrine _____
Sexually Transmitted Disease _____
Respiratory _____
Infectious Disease _____
Cardiovascular _____
Gastrointestinal _____
Renal _____
Musculo-Skeletal _____
Nervous _____
Other _____

Patient Registration Form

Do you suffer from any known allergies? _____

Have you ever reacted to any of the following substances?

Penicillin

_____

Voltarol _____
Latex _____
Other (Please List) _____

Social History

If you smoke, how many cigarettes do you smoke per day? _____

If you are no longer a smoker, when did you give up smoking? _____

If you drink alcohol, how many unites do you consume per week? _____

Do you or have you taken any form of recreational drugs? _____

Where have you "recently" travelled to? (last six months) _____

Have you ever travelled to into an area known to be high-medical risk for any infectious disease?
_____

Family History

Has a member of your immediate family died from a chronic illness or disease?
_____
_____

Are there any significant inherited diseases or genetic conditions in your family that you are aware of?
_____

Mental Health Questions

Have you ever received a psychiatric diagnosis (DSM IV) from a mental health professional, for any of the following; psychophrenia, psychotic episodes, personality disorder, major depression, generalized anxiety disorder
If yes, please specify:
_____
_____

Are you currently under the care of a psychiatrist or any other mental health professional? If yes, please specify:
_____
_____

Menstrual History

At what age did you get your first period? _____

Do you get mid-cycle discomfort or vaginal mucus at your fertile time (ovulation)? _____

Do you use a pad or a tampon or both? _____

Do you get clots with your period? _____

Are your periods excessively heavy or painful? If they are painful, what painkillers do you take?
_____

Do you notice bleeding between periods? _____

How often do your periods come? _____

How long do they generally last? _____

Date of Last Menstrual period? _____

Gynaecology History

Have you had any cervical procedures performed? _____

Do you have any concerns about your sexual life? _____

Do you experience bleeding after sex? _____

Do you experience any pain during sex? _____

Have you suffered from any of the following gynaecologic conditions?

Dysmenorrhoea _____
PMS _____
Deep Dyspareunia _____
Chronic Pelvic Pain _____
Intramenstrual Bleeding _____
PCO or PCOS _____
Recurrent Vaginal Bleeding _____
Endometriosis _____
Pelvic Infection / Sexually Transmitted Disease _____
Other _____

When was your last Pap Smear? _____ Result: _____
Have you had any previous abnormal Pap smears? _____

Obstetric History

Have been pregnant before? _____
If the answer is yes, please provide any information you can below.

Number of Pregnancies _____
Number of deliveries _____
Number of live births _____
Number of term pregnancies (38-42 weeks) _____
Number of preterm pregnancies _____

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Number of ectopic pregnancies _____
Number of spontaneous abortions _____
Number of therapeutic abortions _____
Number of still births _____
Number of neonatal deaths _____

Pregnancy 1
Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Pregnancy 2
Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Pregnancy 3
Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Pregnancy 4
Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Pregnancy 5
Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Previous Treatment

Have you had previous fertility treatment? _____

If yes, please provide as much information as you are able to.

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Treatment 1

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____
Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

Treatment 2

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____
Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

Treatment 3

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____
Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

Treatment 4

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____
Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

Treatment 5

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____

Patient Registration Form

Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

Your records are considered confidential and will not be released without your consent and signature.

I hereby authorise Rotunda IVF to release information to my GP and myself. Please indicate Yes or No: _____

PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

Male Partner Medical History (IF APPLICABLE)

Are you currently on any medications?

_____

Do you have any general medical complaints at present?

_____

Have you had any illnesses or been treated for any medical condition in the past?

_____

Are you currently attending a medical doctor or being treated for a medical condition?

_____

Fertility / Andrology

Have you ever had a semen analysis carried out? _____

If yes, what was the result? _____

Have you been responsible for any pregnancies in the past? _____ Number: _____

Have you ever experienced a groin injury or undergone groin surgery? _____

Have you any history of operations involving the reproductive system? _____

Do you have undescended testicles? _____

Did you ever have mumps? _____

If yes, was this as a child or an adult? _____

Do you have any concerns about your sexual life? _____

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Social History

If you smoke, how many cigarettes do you smoke per day? _____

If you are no longer a smoker, when did you give up smoking? _____

If you drink alcohol, how many unites do you consume per week? _____

Do you or have you taken any form of recreational drugs? _____

Where have you "recently" travelled to? (last six months) _____

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If yes, please specify:
_____
_____

Are you currently under the care of a psychiatrist or any other mental health professional? If yes, please specify:
_____
_____

Surgical History

Have you ever undergone an operation? (If so, please give details).
1. _____Year:_____
2. _____Year:_____
3. _____Year:_____

History of Diseases

Have you ever had any problems in any of the following areas?

Endocrine _____
Sexually Transmitted Disease _____
Respiratory _____
Infectious Disease _____
Cardiovascular _____
Gastrointestinal _____
Renal _____
Musculo-Skeletal _____
Nervous _____
Other _____

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