Committed to Care with Compassion

CLINICAL HISTORY OF THE FEMALE PARTNER

PLEASE FILL IN THIS FORM IN CAPITAL LETTERS

Please leave blank any questions you do not understand or are not sure of how to answer.
We ask you to pay close attention when filling in this questionnaire, as your answers are very important. All information is confidential and will be considered as a part of your medical history

PATIENT	**MALE PARTNER**
SURNAME:	SURNAME:
GIVEN NAME(S):	GIVEN NAME(S):
DATE OF BIRTH:	DATE OF BIRTH:
PROFESSION:	PROFESSION:
PASSPORT NUMBER:	PASSPORT NUMBER:
ADDRESS:	
POSTAL CODE:	
CITY:	
DISTRICT:	
COUNTRY:	
TELEPHONE NUMBERS: HOME: WORK: MOBILE: OTHERS: FAX:	
E-MAIL:	

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CLINICAL HISTORY OF THE FEMALE PATIENT

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NAME AND SURNAME:
DATE OF BIRTH:
DURATION OF INFERTILITY [since when have you been trying to get pregnant (month and year)]:

FAMILY HISTORY: Among the members of your family (parents, brothers and sisters, aunts and uncles, children, nieces and nephews), is there any history of
HEREDITARY DISEASES:
CHILDREN BORN WITH DEFORMITIES: (if present, are their parents cousins of first degree?)
PULMONARY EMBOLISM OR THROMBOSIS:
BREAST CANCER:
THYROID DISORDERS:
OTHER RELEVANT HEALTH CONDITIONS:

PERSONAL MEDICAL HISTORY (PAST OR PRESENT):
GENETIC DISEASE:
HEALTHY CARRIER OF A HEREDITARY DISEASE (E.G., THALASSEMIA/MEDITERRANEAN-ANEiVIIA, DREPAN-0-C4TOSIS/SICKLE CELL ANEMIA, MUCOVISCIDOS1S/CYSTIC FIBROSIS):
OTHER TYPES OF ANEMIA:
CANCER:
INFECTIOUS DISEASES (E.G., HEPATITIS B, HEPATITIS C, HIV, SYPHILIS...):
PELVIC/GENITAL INFECTIONS:
ENDOMETRIOSIS:

DIABETES:

NEUROLOGICAL, PSYCHOLOGICAL, PSYCHIATRIC DISORDERS, DEPRESSION, ANXIETY:
EPILEPSY:
MIGRAINE:
THROMBOSIS:
HEART DISEASE:
HYPERTENSION (HIGH BLOOD PRESSURE):
THYROID DISORDERS:
ASTHMA:
NEPHRO-UROLOGICAL DISORDERS:
HEPATOPATHIES (LIVER DISEASES):
GASTRIC/DUODENAL ULCERS:
CROHN'S DISEASE:
TUBERCULOSIS:
VASCULAR CEREBRAL EVENTS:
MULTIPLE SCLEROSIS:
OTHER RELEVANT HEALTH CONDITIONS:
ALLERGIES TO MEDICATIONS/LATEX/METALS:
REACTIONS TO ANESTHETICS:
BLOOD TRANSFUSION:
MEDICATIONS TAKEN IN THE LAST 6 MONTHS:
SMOKING HABITS (CIGARS/CIGARETTES PER DAY):
ALCOHOL CONSUMPTION (GLASSES PER DAY):
DRUG CONSUMPTION:
PREVIOUS TESTS OF FERTILITY (PLEASE INDICATE THE DATES THE TESTS WERE PERFORMED): HORMONAL TESTS (FSH, LH, E2, AMH, TSH, PROLACTIN ETC.):

HYSTEROSALPINGOGRAPHY:
HYSTEROSCOPY:
LAPAROSCOPY:
KARYOTYPE (CHROMOSOME ANALYSIS):
OTHER TESTS:

PREVIOUS SURGERIES APART FROM THOSE DESCRIBED ABOVE [APPENDECTOMY, MYOMA/FIBROID RESECTION, OVARIAN CYSTS, CERVICAL SURGERY (CONE BIOPSY) ETC.]:

MENSTRUAL CYCLE:
YOUR AGE AT YOUR FIRST MENSTRUATION:
FIRST DAY OF YOUR LAST SPONTANEOUS MENSTRUATION:
ARE YOUR CYCLES USUALLY REGULAR?
LENGTH OF MENSTRUAL CYCLES (HOW MANY DAYS ARE THERE USUALLY BETWEEN DAY 1 OF TWO CONSECUTIVE PERIODS):
LENGTH OF MENSTRUAL BLEEDING (DAYS):
DO YOU SUFFER FROM PAINFUL MENSTRUAL PERIODS?
WHICH CONTRACEPTIVE METHODS HAVE YOU USED IN THE PAST? (NONE, PILLS, IUD, OTHERS)

PREVIOUS PREGNANCIES WITH YOUR CURRENT PARTNER:	YES	NO
PREGNANCIES WITH DELIVERY (YEAR, PREGNANCY WEEK, COMPLICATIONS, MODE OF DELIVERY):		
MISCARRIAGES (YEAR, PREGNANCY WEEK, CURETTAGE YES/NO):		
TERMINATION OF PREGNANCY (VOLUNTARY OR FOR MEDICAL INDICATIONS; YEAR, PREGNANCY WEEK):		
ECTOPIC (EXTRAUTERINE) PREGNANCIES (YEAR, PREGNANCY WEEK, TREATMENT):		

PREVIOUS PREGNANCIES WITH YOUR PREVIOUS PARTNER(S):	YES	NO

PREGNANCIES WITH DELIVERY (YEAR, PREGNANCY WEEK, COMPLICATIONS, MODE OF DELIVERY):

Conceive IVF
FERTILITY & GYNAECOLOGY CENTRE
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MISCARRIAGES (YEAR, PREGNANCY WEEK, CURETTAGE YES/NO):
TERMINATION OF PREGNANCY (VOLUNTARY OR FOR MEDICAL INDICATIONS; YEAR, PREGNANCY WEEK):
ECTOPIC (EXTRAUTERINE) PREGNANCIES (YEAR, PREGNANCY WEEK, TREATMENT):

6. PREVIOUS FERTILITY TREATMENTS				
CENTER	YEAR	PROCEDURE (INDUCED OVULATION, INSEMINATION, IVF, ICSI, USE OF DONOR SPERM/EGGS, TRANSFER OF FROZEN EMBRYOS)	EMBRYOS TRANSFERRED AND CRYOPRESERVED	OUTCOME

Date:
Signed (by the female patient):

501, 5th Floor, White Square,
Hinjawadi, Wakad, Pune-411057.
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