Health Questionnaire for Female Infertility Patients

Name: _____

DOB: _____ Date: _____

MEDICAL HISTORY	YES	NO	ADDITIONAL INFORMATION
Diabetes			
Epilepsy			
Clots in legs/lungs			
High Blood Pressure			
Heart problems			
Kidney/Liver problems			
Thyroid problems			
Gynecological problems			
Back problems			
Depression			
Thalassemia			
Infertility Treatment			
Have you had a general anesthesia?			
Did you have any problems?			
Any other relevant Medical/Surgical History			
Last Pap smear date:			
Any abnormal Pap Smears?			
Any known Infectious Diseases?			

Please List any operations and year:

Type of Operation	Year

Please list Current medications and dosages:

Name	Dosage

Obstetric History and Miscarriages

Year	Delivery Type / Miscarriage/Ectopic	Gestation	Birth Weight/Sex	Complications	Outcome

Family History	Yes	No	Additional Information
Diabetes			
Heart Disease			
High Blood Pressure			
Cancer			
Clots in the legs or lungs			
Cystic Fibrosis			
Down's Syndrome			
Endometriosis			
Kidney Disease			
Polycystic Ovarian Disease			
Premature Menopause (before 40)			
Spina Bifida			
Thalassemia			
Congenital abnormalities			
Genetic Illnesses			
Any other conditions			

Social History	Yes	No	Additional Information
Drug Allergies			
Non drug Allergies			
Smoker			
Alcohol			
Recreational drugs			

Menstrual History			
Age at first period	Years		
Are your periods regular?	Yes	No	
How often do you have your period? (length of cycle i.e. 28-35days)	Days		
Bleeding between periods	Yes	No	
Length of bleeding each cycle	Days		
How heavy is the loss	Heavy	Moderate	Light
Pain with periods	Yes	No	
Pain with sex	Yes	No	
Bleeding after sex	Yes	No	
Are you aware of your ovulation	Yes	No	
Have you used ovulation kits or something similar to determine when you are ovulating	Yes	No	
First day of last period	/ /20		

General

How long have you been trying for a baby?		
Type of prior contraception used?		
When was it ceased?		
Frequency of sex (times/week)		
Do you experience leaking of breast milk?	**Yes**	**No**
Have you had any history of pelvic infection or sexually transmitted diseases?	**Yes**	**No**
How do you describe your diet?		
Very healthy Balanced Reasonably healthy Unhealthy (Please circle)		
Do you eat fruit and vegetables?	**Yes**	**No**
Are you taking Folic Acid Supplements?	**Yes**	**No**
Do you have abnormal hair growth under the chin, on the belly etc.?	**Yes**	**No**
Do you experience any sexual problems?	**Yes**	**No**
Have you had any tests for fertility?	**Yes**	**No**
What is your impression as to the cause of your difficulty to achieve a pregnancy?		
Any other relevant information.		

PERSONAL DETAILS

Title _____Given Name: _____ Surname:_____

Address: _____Postcode: _____

Postal Address: _____Postcode: _____

Date of Birth: _____ Home Phone: _____

Work Phone: _____ Mobile Phone: _____

Email: _____

Occupation: _____

Next of Kin: _____ Relationship:_____

Next of Kin Contact Number: _____

Current GP: _____

Medicare Number: _____Ref: _____ Expiry: _____

Health Fund: _____Membership Number: _____

Special Interest: _____

How did you hear about us? GP/Specialist /Advertising /Friend/Family /Google /Internet

Other:_____

CONSENT TO RELEASE OF MEDICAL INFORMATION

I give my consent to NG Gynehealth, or their agents and advisors, to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care.

I authorize those medical practitioners or bodies to release such information, which may include sensitive health information, to NG Gynehealth, or their agents and advisors, as may be requested.

I understand that unless I advise otherwise, NG Gynehealth will continue to liaise with the doctors nominated above on matters related to my ongoing care.

OTHER

I give permission for NG Gynehealth to contact me via SMS/Phone regarding appointment details and results.
I give permission for NG Gynehealth to contact me through email.
I give permission to NG Gynehealth to take clinical photographs and use them for educational purposes.
I give permission to NG Gynehealth to take identification photographs to attach to my clinical chart.
I understand it is my responsibility to call the clinic for results**.**

Privacy Statement

Your information will be kept confidential in this practice at all times. All our staff are governed by the Policy Act of 1988. If you have any concern regarding your privacy being disclosed, please discuss this with your Doctor.

I consent to the collection and release of personal information about me to other healthcare professionals when it is relevant to my health and care.

Signature: _____ Date: _____