

**Medical History form for consultation at Victoria Fertility Centre****Please write clearly**

Full Name: \_\_\_\_\_  
(as on Care Card)

Date of Birth: \_\_\_\_\_  
(day/month/year)

Care Card Number \_\_\_\_\_

Family Doctor \_\_\_\_\_

Home Address: \_\_\_\_\_  
(include postal code)  
\_\_\_\_\_  
\_\_\_\_\_

e mail address \_\_\_\_\_

Phone number Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_

Name of your partner ( as it appears on his care card)

\_\_\_\_\_

How long have you been trying to conceive with your current partner ?  
 ( indicate how many months or years you have been having unprotected  
 intercourse with your current partner)

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Have you ever been pregnant before ? Please indicate the dates of these  
 pregnancies and the outcomes. For instance, if you had a miscarriage –  
 indicate that you did and say how far along you were. If you had a previous  
 live birth – indicate how many weeks you were when you delivered, how  
 you delivered (e.g. by c section, vaginally) and indicate the weight and sex  
 of the baby you delivered. Please also indicate who the father of the baby  
 was. ( i.e. was the father your current partner or a previous partner)

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### **Gynecological History**

Age when you had first period \_\_\_\_\_

Do you have regular cycles ? Yes or no \_\_\_\_\_  
 If you do not have a cycle every month – please explain

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How long are your cycles ? (e.g. 28 days,25 days) \_\_\_\_\_

How many days do you usually bleed for \_\_\_\_\_

Do you spot for a few days before your period ? \_\_\_\_\_

Do you have pain with your periods ? \_\_\_\_\_

If yes – describe please \_\_\_\_\_

\_\_\_\_\_

Do you have pain with intercourse ? \_\_\_\_\_

Have you had a Pap in the last year ? \_\_\_\_\_

Have you ever been treated for an abnormal Pap ? e.g. colposcopy, cryotherapy, laser, LEEP, Cone biopsy. If so, please give details and dates.

\_\_\_\_\_

Have You ever been treated for Herpes, chlamydia, Gonorrhoea, syphilis, genital warts or trichomonas ? If so please indicate the dates you were treated.

\_\_\_\_\_

Have you ever had a laparoscopy or hysteroscopy ? if yes – when, by whom, and what were the findings ?

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Have you ever had a hysterosalpingogram was sonohysterogram ? ( these are tests to check your uterine cavity and fallopian tubes)

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### **Fertility Treatments**

Have you previously been seen at a Fertility Clinic ? If so where and when.

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Can you give details of previous fertility treatments e.g. Clomid, Superovulation and IUI, IVF.

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### **Past medical History**

Do you have any ongoing medical problems

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Do you have any allergies ? If you do please list these.

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Are you allergic to Latex                      Yes                      No

Have you ever had any surgery before. Please list below:

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Please list any medications (and vitamins) you are on (Include dosages)

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**Personal History**

How many years have you been with your current partner ? \_\_\_\_\_

What is your Occupation ? \_\_\_\_\_

Do you smoke cigarettes ? \_\_\_\_\_

Do you smoke Marijuana ? \_\_\_\_\_

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Do you drink coffee ? ( how much) \_\_\_\_\_

What exercise do you do ? \_\_\_\_\_

Have you tried to be pregnant with another partner ? \_\_\_\_\_

If yes, details please \_\_\_\_\_

### **Family History**

Age and health of Mother \_\_\_\_\_

Age and health of Father \_\_\_\_\_

List siblings by age please \_\_\_\_\_

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Is there any Family history of.....

Diabetes	Yes	No
Hypertension (high BP)	Yes	No
Connective tissue disease e.g. Lupus,rheumatoid	Yes	No
Blood clots i.e. Deep vein thrombosis	Yes	No
Stroke at a young age	Yes	No
Exposure to Diethyl stilboestrol (DES)	Yes	No
Alcoholism	Yes	No
Mental illness e.g. depression,schizophrenia,OCD	Yes	No
Genetic disorders		
e.g.Cystic fibrosis,Polycystic Kidneys,Downs etc	Yes	No
Cancer ( any forms)	Yes	No
Neurological disorders.e.g Epilepsy	Yes	No
Recurrent miscarriages	Yes	No

If yes to any of the above – please describe in detail below.....

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**Review of Current Health**

Height \_\_\_\_\_

Weight \_\_\_\_\_

Body Mass Index. \_\_\_\_\_

( you can calculate your body mass index by going to this website..  
[www.nhlbisupport.com/bmi/](http://www.nhlbisupport.com/bmi/) )

Please describe any health problems or other concerns that you currently have.

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