

Medical History form for consultation at Victoria Fertility Centre

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 _____

What is your partner's name (as it appears on her care card_

Personal History

How long have you been with your current partner ? _____

Occupation: _____

Do you smoke cigs or Marijuana ? If so how much _____

Do you drink alcohol ? how many per week ? _____

Do you drink coffee ? How many cups/day ? _____

What exercise do you do ? _____

Do you cycle more than an hour per day ? _____

Do you use a hot tub, and if so how many hours per week ? _____

Reproductive History

Have you had any children or any pregnancies with your current partner ?

If so, please give details i.e. number and ages of children, or details of miscarriages

Do you have any children with previous partners ? Yes No

Please give details

Have you ever tried to achieve a pregnancy with another female partner ?

Have you had a semen analysis ? if yes – when, and what were the results

Have you ever seen a Urologist ? If yes,who did you see, what for and what advice or treatment was given you ?

Have you ever had an ultrasound of the scrotum\testes ?

Have you ever had an injury to the testes ?

Have you ever been treated for any sexually transmitted infections ?

Have you ever been treated for epididymitis or prostatitis ?

You have any concerns or problems related to libido, erections, ejaculating, or urinary stream ?

Have you ever taken steroids ? (And if so when was the last time you took them ?)

Past medical History

Do you have any ongoing medical problems that require medication ?

Allergies Yes No if yes, please describe_____

Are you allergic to Latex Yes No

Have you ever had ANY surgery before ? Please list below with dates....

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

Family History

Age and health of Mother _____

Age and health of Father _____

List siblings by age please _____

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

Infertility (specifically have any of the male or female members of your family had problems with fertility

Yes No

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

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/)

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