



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)

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)

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

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 ?

Fertility Treatments

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

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

Personal History

How many years have you been with your current partner ? _____

What is your Occupation ? _____

Do you smoke cigarettes ? _____

Do you smoke Marijuana ? _____

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 _____

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.....

Past medical History

Do you have any ongoing medical problems

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

Are you allergic to Latex Yes No

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

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