

Name: _____ **Tel:** _____

Email: _____

1. **Age:** _____

2. **Previous Pregnancy:** YES / NO

How many previous pregnancies: _____

How many pregnancies beyond 28 weeks gestation: _____

3. **Still menstruating:** YES / NO

Date of last normal menstrual period: ____ / ____ / _____

4. **Smoker:** YES / NO

5. **History of current or previous malignancy:** YES / NO

If yes, provide details: _____

6. **Any co-existing cause of infertility:**

Endometriosis YES / NO

Auto-immune disease YES / NO

Male factor infertility YES / NO

Cytotoxic drug usage YES / NO

7. **Previous surgery whereby ovarian tissue was removed** YES / NO

8. **Previous Uterine Artery Embolisation for treatment of fibroids/adenomyosis** YES / NO

9. **Last papsmear:** ____ / ____ / _____ **Result:** _____

10. **Previous surgery:** YES / NO

Provide details: _____

11. **Any co-morbid illnesses:** YES / NO

If yes, provide details: _____

12. **Current Medications:** YES / NO

13. **Allergies:** YES / NO, If Yes, provide details: _____

14. **Names of medications and Dosages:**

15. **Previous Fertility History:**

IVF: YES / NO

No of cycles and outcomes
