

Sims Fertility Clinic		Form No.	A-F-002a
Revision No.	07	Effective Date	22/11/2010

New Patient Appointment Form (Postal)

PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

FEMALE PATIENT NAME;

MAIDEN NAME (If Applicable)

FULL POSTAL ADDRESS;

DATE OF BIRTH;

NATIONALITY:

PPS NUMBER;

DPS NUMBER ; (if applicable)

TELEPHONE NO's:

Home: Work (or 9-5pm): Mobile:

OK to Leave message (please tick):

Home Work (or 9-5pm) Mobile

PERSONAL EMAIL ADDRESS;

OCCUPATION;

ALLERGIES:

GP NAME:

GP ADDRESS; Full Postal Address:

Did you have a medical Referral to this clinic? Yes No

If so, please state name of referring Doctor:

If you were not referred by a doctor, please state how you heard of Sims Clinic;

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FRIEND: ----- RELATIVE: -----

NEWSPAPER: ----- RADIO: -----

INTERNET: ----- T.V: -----

DO YOU HAVE HEALTH INSURANCE? (Please CIRCLE) YES NO
 (If you answered "YES" to the above question, please complete this section)

INSURANCE CO. (VHI/ QUINN/ VIVSA/ OTHER) -----

NAME OF SUBSCRIBER; -----

MEMBERSHIP NO. ----- PLAN-----

Your records are considered confidential and will not be released without your consent and signature.

Please sign the release below:

I hereby authorise the Sims Fertility Clinic to release information to my GP and myself.

PATIENT SIGNATURE: ----- DATE: -----

I have been given the SIMS Fertility Clinic booklet and I will take time to read the relevant sections including that on complications associated with IVF.

 Signed (Female Patient)

 Date

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PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

PARTNER'S NAME: **SEX:**

DATE OF BIRTH:

NATIONALITY:

TELEPHONE NO's:

Home: Work (or 9-5pm): Mobile:

OK to Leave message (please tick):

Home Work (or 9-5pm) Mobile

PERSONAL EMAIL ADDRESS;

OCCUPATION;

ALLERGIES:

GP NAME:

GP ADDRESS; Full Postal Address:

.....

.....

Your records are considered confidential and will not be released without your consent and signature.

Please sign the release below:

I hereby authorise the Sims Fertility Clinic to release information to my GP and myself.

PATIENT SIGNATURE: DATE:

I have been given the SIMS Fertility Clinic booklet and I will take time to read the relevant sections including that on complications associated with IVF.

Signed (Male Patient)

Date

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PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS
Female Patient Medical History

Please complete this form to the best of your knowledge. If there are any question you are uncertain about, do not worry. The details will be discussed with the doctor at the first appointment. The form will take some time to complete. If you have any questions or queries, please do not hesitate to contact us.

If you have further information, medical records or otherwise, please bring them to the first appointment so that your doctor can review them.

Have you ever undergone an operation? (If so, please give details).

- 1. _____ Year: _____
- 2. _____ Year: _____
- 3. _____ Year: _____

Are you currently on any medications? _____

How long have you been trying to conceive (duration)? _____

Have you used contraception before? _____ (If yes, please describe)
 _____ Duration: _____
 _____ Duration: _____

Are you currently attending a medical doctor or being treated for an illness or medical condition?

Have you had any illnesses or been treated for a medical condition in the past?

Do you have any general medical complaints at present?

Are you currently using any non-fertility medications?

Have you ever had any problems in any of the following areas?

- Endocrine _____
- Sexually Transmitted Disease _____
- Respiratory _____
- Infectious Disease _____
- Cardiovascular _____
- Gastrointestinal _____
- Renal _____
- Musculo-Skeletal _____
- Nervous _____
- Other _____

Do you suffer from any known allergies? _____

Have you ever reacted to any of the following substances?

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Penicillin _____
 Voltarol _____
 Latex _____
 Other (Please List) _____

Social History

If you smoke, how many cigarettes do you smoke per day? _____

If you are no longer a smoker, when did you give up smoking? _____

If you drink alcohol, how many unites do you consume per week? _____

Do you or have you taken any form of recreational drugs? _____

Where have you "recently" travelled to? (last six months) _____

Have you ever travelled to into an area known to be high-medical risk for any infectious disease?

Family History

Has a member of your immediate family died from a chronic illness or disease?

Are there any significant inherited diseases or genetic conditions in your family that you are aware of?

Menstrual History

At what age did you get your first period? _____

Do you get mid-cycle discomfort or vaginal mucus at your fertile time (ovulation)? _____

Do you use a pad or a tampon or both? _____

Do you get clots with your period? _____

Are your periods excessively heavy or painful? If they are painful, what painkillers do you take?

Do you notice bleeding between periods? _____

How often do your periods come? _____

How long do they generally last? _____

Date of Last Menstrual period? _____

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Gynaecology History

Have you had any cervical procedures performed? _____

Do you have any concerns about your sexual life? _____

Do you experience bleeding after sex? _____

Do you experience any pain during sex? _____

Have you suffered from any of the following gynaecologic conditions?

- Dysmenorrhoea _____
- PMS _____
- Deep Dyspareunia _____
- Chronic Pelvic Pain _____
- Intramenstrual Bleeding _____
- PCO or PCOS _____
- Recurrent Vaginal Bleeding _____
- Endometriosis _____
- Pelvic Infection / Sexually Transmitted Disease _____
- Other _____

When was your last Pap Smear? _____ Result: _____

Have you had any previous abnormal Pap smears? _____

Obstetric History

Have been pregnant before? _____

If the answer is yes, please provide any information you can below.

- Number of Pregnancies _____
- Number of deliveries _____
- Number of live births _____
- Number of term pregnancies (38-42 weeks) _____
- Number of preterm pregnancies _____
- Number of ectopic pregnancies _____
- Number of spontaneous abortions _____
- Number of therapeutic abortions _____
- Number of still births _____
- Number of neonatal deaths _____

Pregnancy 1

- Gestational Age (weeks) _____
- Pregnancy Outcome _____
- Mode of Delivery _____
- Delivery Outcome _____
- Other/ Any complications _____

Pregnancy 2

- Gestational Age (weeks) _____
- Pregnancy Outcome _____
- Mode of Delivery _____
- Delivery Outcome _____
- Other/ Any complications _____

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Pregnancy 3

Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Pregnancy 4

Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Pregnancy 5

Gestational Age (weeks) _____
Pregnancy Outcome _____
Mode of Delivery _____
Delivery Outcome _____
Other/ Any complications _____

Previous Treatment

Have you had previous fertility treatment? _____

If yes, please provide as much information as you are able to.

Treatment 1

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____
Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

Treatment 2

Date _____
Treatment Type _____
Drugs (days) _____
Follicles / Eggs _____
Injected / Fertilised _____
Number of embryos Transferred _____
Embryo day / quality _____
Number / day frozen _____
Outcome _____
Comments _____

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Treatment 3

Date _____
 Treatment Type _____
 Drugs (days) _____
 Follicles / Eggs _____
 Injected / Fertilised _____
 Number of embryos Transferred _____
 Embryo day / quality _____
 Number / day frozen _____
 Outcome _____
 Comments _____

Treatment 4

Date _____
 Treatment Type _____
 Drugs (days) _____
 Follicles / Eggs _____
 Injected / Fertilised _____
 Number of embryos Transferred _____
 Embryo day / quality _____
 Number / day frozen _____
 Outcome _____
 Comments _____

Treatment 5

Date _____
 Treatment Type _____
 Drugs (days) _____
 Follicles / Eggs _____
 Injected / Fertilised _____
 Number of embryos Transferred _____
 Embryo day / quality _____
 Number / day frozen _____
 Outcome _____
 Comments _____

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Male Partner Medical History (IF APPLICABLE)**

Are you currently on any medications?

Do you have any general medical complaints at present?

Have you had any illnesses or been treated for any medical condition in the past?

Are you currently attending a medical doctor or being treated for a medical condition?

Fertility / Andrology

Have you ever had a semen analysis carried out? _____

If yes, what was the result? _____

Have you been responsible for any pregnancies in the past? _____ Number: _____

Have you ever experienced a groin injury or undergone groin surgery? _____

Have you any history of operations involving the reproductive system? _____

Do you have undescended testicles? _____

Did you ever have mumps? _____

If yes, was this as a child or an adult? _____

Social History

If you smoke, how many cigarettes do you smoke per day? _____

If you are no longer a smoker, when did you give up smoking? _____

If you drink alcohol, how many unites do you consume per week? _____

Do you or have you taken any form of recreational drugs? _____

Where have you "recently" travelled to? (last six months) _____

Have you ever travelled to into an area known to be high-medical risk for any infectious disease?

Surgical History

Have you ever undergone an operation? (If so, please give details).

1. _____ Year: _____

2. _____ Year: _____

3. _____ Year: _____

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History of Diseases

Have you ever had any problems in any of the following areas?

- Endocrine _____
- Sexually Transmitted Disease _____
- Respiratory _____
- Infectious Disease _____
- Cardiovascular _____
- Gastrointestinal _____
- Renal _____
- Musculo-Skeletal _____
- Nervous _____
- Other _____

Do you suffer from any known allergies? _____

Have you ever reacted to any of the following substances?

- Penicillin _____
- Voltarol _____
- Other (Please List) _____

Have you been treated for an STD (Sexually Transmitted Disease)?

How many units of alcohol do you consume per week? (1 pint = 2 units) _____

Do you smoke? If yes, how many per week? _____

If you are no longer a smoker, when did you give up smoking? _____

Has a member of you immediate family died from a chronic illness or disease?

Are there any significant inherited diseases in your family that you are aware of? e.g. heart disease, diabetes, cystic fibrosis etc. _____

Do you have any other general medical complaints at present? _____

Have you ever experienced a groin injury? _____

Do you have undescended testicles? _____

Did you ever have mumps either as a child or an adult? _____

Have you had a semen analysis carried out? _____

If yes, was it normal? If not, please describe any abnormalities found

Do you have any pregnancies from a previous relationship? _____

Do you have any concerns about your sexual life?
