

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

PLEASE COMPLETE THE FOLLOWING FORM INCLUDING THE MEDICAL HISTORY SECTION. UPON RECEIPT OF THIS FORM, YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

FEMALE PATIENT NAME:

MAIDEN NAME (If Applicable)

FULL POSTAL ADDRESS;

DATE OF BIRTH;

NATIONALITY:

PPS NUMBER;

DPS NUMBER; (if applicable)

TELEPHONE NO's:

Home: Ok to leave a message? _____

Work (or 9-5pm): Ok to leave a message? _____

Mobile: Ok to leave a message? _____

PERSONAL EMAIL ADDRESS;

OCCUPATION;

KNOWN ALLERGIES:

GP NAME:

GP ADDRESS (Full);

Do you have a medical Referral to Sims? _____ Name of referring Doctor: _____

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

FRIEND: **RELATIVE:**

NEWSPAPER: **RADIO:**

INTERNET: **T.V:**

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

PARTNER'S NAME: ----- **SEX:** _____

DATE OF BIRTH: -----

NATIONALITY: -----

TELEPHONE NO's:

Home: ----- Ok to leave a message? _____

Work (or 9-5pm): ----- Ok to leave a message? _____

Mobile: ----- Ok to leave a message? _____

PERSONAL EMAIL ADDRESS; -----

OCCUPATION; -----

KNOWN ALLERGIES: -----

GP NAME: -----

GP ADDRESS; Full Postal Address: -----

Health Insurance: YES NO

Provider: -----

Policy Number: -----

Plan: -----

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

**New Patient Appointment Form
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.

Height: _____

Weight _____

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 _____

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

Do you suffer from any known allergies? _____

Have you ever reacted to any of the following substances?

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?

Mental Health Questions

Have you ever received a psychiatric diagnosis (DSM IV) from a mental health professional, for any of the following; psychophrenia, psychotic episodes, personality disorder, major depression, generalized anxiety disorder
 If yes, please specify:

Are you currently under the care of a psychiatrist or any other mental health professional? If yes, please specify:

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

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? _____

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? _____

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

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 _____

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 _____

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

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 _____

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 _____

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

Treatment 5

Date _____

Treatment Type _____

Drugs (days) _____

Follicles / Eggs _____

Injected / Fertilised _____

Number of embryos Transferred _____

Embryo day / quality _____

Number / day frozen _____

Outcome _____

Comments _____

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

I hereby authorise the Sims Fertility Clinic to release information to my GP and myself. Please indicate Yes or No: _____

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

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? _____

Do you have any concerns about your sexual life? _____

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?

Sims IVF		Form No.	PC-F-002b
Revision No.	05	Effective Date	08.09.2017

New Patient Appointment Form

Mental Health Questions

Have you ever received a psychiatric diagnosis (DSM IV) from a mental health professional, for any of the following; psychophrenia, psychotic episodes, personality disorder, major depression, generalized anxiety disorder
If yes, please specify:

Are you currently under the care of a psychiatrist or any other mental health professional? If yes, please specify:

Surgical History

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

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

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) _____

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?

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

I hereby authorise the Sims Fertility Clinic to release information to my GP and myself. Please indicate Yes or No: _____