



Pre-Appointment History Sheet

Please fill in the below table with your details:

Date of appointment:

Title			
First Name			
Surname			
Date of Birth and age			
Occupation			
Do you smoke? (please circle)	Yes No	If yes, how many per day? .....	
How is your alcohol intake? (please circle)	None	Low	Moderate High
Are you on any regular medications?			
Do you have any allergies?	Yes No	Allergies:	
What do you consider your main issue?	<input type="checkbox"/> Miscarriage <input type="checkbox"/> Failed IVF <input type="checkbox"/> PCOS <input type="checkbox"/> Fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ectopic <input type="checkbox"/> Delayed Fertility <input type="checkbox"/> Stillbirth <input type="checkbox"/> Male Fertility Factors		
Do you have a registered disability?	Yes No	If yes, please state .....	
Ethnicity			
Weight in <b>Kg:</b> <b>Stones &amp; lbs:</b>	Height in <b>Cm:</b> <b>Feet &amp; inches:</b>	BMI:	

Please fill in the below table with your partner's details (if relevant):

Title			
First Name			
Surname			
Date of Birth and age			
Occupation			
Do you smoke? (please circle)	Yes No	If yes, how many per day? .....	
How is your alcohol intake? (please circle)	None	Low	Moderate High
Are you on any regular medications?			
Do you have any children from a previous relationship?	Yes No	If yes: how many, sex and what ages?	
Do you have any allergies?	Yes No	Allergies:	
Do you have a registered disability?	Yes No	If yes, please state .....	
Ethnicity			
Weight <b>Kg:</b> <b>Stones &amp; lbs:</b>	Height in <b>Cm:</b> <b>Feet &amp; inches:</b>	BMI:	



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How long have you been with your partner? .....

Please fill in the below table with the number you have had for all those applicable:

<u>Children</u> (Sex, Age, Name, Weight and delivery mode)	<u>Miscarriages and/or chemical pregnancies</u>	<u>IVF/ICSI</u>	<u>Ectopic/Pregnancy of unknown location</u>	<u>Stimulated Cycles &amp; medication used</u>  (i.e. Letrozole/Clomid)	<u>Stillbirths</u>
		<u>Fresh</u> <u>Frozen</u> <u>Donor</u>			

Please fill in the below table for each pregnancy you have had in the order from your first to the latest:

(If you have had more than 5 then please, continue on the back of the sheet)

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
<b><u>Pregnancy Outcome</u></b> Please circle	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child
<b><u>Year</u></b>					
<b><u>Type of conception</u></b> Please circle	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation
<b><u>Gestation miscarriage diagnosed at</u></b>					
<b><u>Type of Miscarriage</u></b> i.e complete/missed  <b><u>Gestation miscarriage size</u></b>					
<b><u>Management of Miscarriage</u></b> Please circle	Natural Surgery Tablets	Natural Surgery Tablets	Natural Surgery Tablets	Natural Surgery Tablets	Natural Surgery Tablets



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Please fill in table below for any IVF attempts you may have had:

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
<b>Type of IVF</b> Please circle	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor
<b>IVF/ICSI</b>					
<b>Where IVF done</b>					
<b>Year</b>					
<b>Number of eggs collected</b>					
<b>Number of fertilised embryos</b>					
<b>Number of embryos or blastocysts transferred</b>					
<b>Outcome</b> Please circle	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt

Please fill in table below with your gynaecological history:

<b>Cycle length</b>	
<b>Number of days of bleeding</b>	
<b>Blood Loss</b> Please circle	Light                      Average                      Heavy
<b>Last Menstrual Period</b> (Please leave blank for Mr Shehata to fill in)	
<b>Do you get any bleeding between periods?</b> Please circle	Yes  No
<b>Do you get any bleeding after intercourse?</b> Please circle	Yes  No
<b>Do you get any pain during intercourse?</b> Please circle	Yes  No
<b>Have you had any of the following investigations and if so in what year:</b> Please circle	Hysteroscopy  Laparoscopy



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	HyFosy HSG
<b>Are you up to date with your cervical smears?</b> Please circle	Yes  No
<b>Have you ever had an abnormal smear?</b> Please circle	Yes  No  If yes in which year .....  If yes how was it treated? .....

Please fill in table below with your medical history:

<b><u>Do you have any medical history of:</u></b>	
<b><u>Diabetes</u></b> Please circle	Yes:      Type I      Type II  No
<b><u>High Blood Pressure</u></b> Please circle	Yes  No
<b><u>Glaucoma</u></b> Please circle	Yes  No
<b><u>Thyroid</u></b> Please circle	Yes  No
<b><u>Asthma</u></b> Please circle	Yes  No
<b><u>Thrombosis</u></b> <i>i.e. deep vein thrombosis/pulmonary embolism</i>  Please circle	Yes  No



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<p><b>Cardiac Abnormalities</b> <i>i.e. palpitations</i></p> <p>Please circle</p>	<p>Yes</p> <p>No</p>
<p><b>Other medical issues</b></p>	
<p><b>Do you take any multivitamins while you are trying?</b></p>	<p>If Yes please provide the name of them below:</p>

Please fill in table below with your family history:

<p><b>Do you have any family history of:</b></p>	
<p><b>Diabetes</b> Please circle and if yes who and which type?</p>	<p>Yes – Type I .....</p> <p>                  Type II .....</p> <p>No</p>
<p><b>High Blood Pressure</b> Please circle and if yes who?</p>	<p>Yes - .....</p> <p>No</p>
<p><b>Glaucoma</b> Please circle and if yes who?</p>	<p>Yes - .....</p> <p>No</p>
<p><b>Thyroid</b> Please circle and if yes who?</p>	<p>Yes - .....</p> <p>No</p>
<p><b>Recurrent miscarriages</b> Please circle and if yes who?</p>	<p>Yes - .....</p> <p>No</p>
<p><b>Other family history</b></p>	



**Pre-Appointment History Sheet**

Please fill out the below table with your full address and contact details:

<b><u>Full address:</u></b>	
<b><u>Contact number:</u></b>	
<b><u>Email address:</u></b>	
<b><u>Partner's number:</u></b>	
<b><u>Partner's email address:</u></b>	

Please fill out the below table with your next of kin's contact details:

<b><u>Name:</u></b>	
<b><u>Contact number:</u></b>	

Please fill out the below table with your GP details

*If you would not like your GP to be copied into any correspondence, please circle no and leave the table blank*

<b><u>Would you like all correspondence to be copied to your GP please fill in the details below</u></b>	Yes	No
<b><u>GP Surgery</u></b>		
<b><u>GP name</u></b>		
<b><u>GP surgery address</u></b>		
<b><u>GP telephone number</u></b>		
<b><u>GP email address</u></b>		

**We ask if you could kindly send any relevant results or correspondence to us prior to your appointment, as unfortunately results brought with you on the day will not be reviewed. Going through numerous pages of results during the consultation, will take up the majority of the consultation and take away from the value of the discussion into your history and the tests going forward.**