FEMALE history

Thank you for choosing My Fertility Care.
Please take a moment to provide a complete and detailed history. Please return form to: info@myfertilitycare.com.au

Dr Ashley Fong
Endocrinologist & Fertility Specialist

Todays' date: _____

Your name _____ Your Age _____ Height (cm) _____ Weight _____

Partner's Name _____ Partner's Age _____ Height (cm) _____ Weight _____

Best contact no: _____ Email address _____

Office Use	Plan
G P M T cycles: SFA AMH Tubes Last pelvic US	

What topics would you like to cover today: _____

_____

How long have you been trying for a baby with your current partner: _____

Have you seen a Fertility Specialist before? No ☐ Yes ☐- When: _____

What was their assessment: _____

Name of Fertility specialist and Centre: _____

What fertility treatments have you tried: _____

_____

FERTILITY

PREGNANCY

Number of pregnancies: _____*(please provide details below)*

Number of births _____	Miscarriages (no.): _____	Terminations (no.): _____	Ectopic (no.): _____
	Please record when this occurred **month/Year** & how many weeks of pregnancy		
Child's age: _____ M / F NV / C	_____	_____	_____ R/L
Child's age: _____ M / F NV / C	_____	_____	_____ R/L
Child's age: _____ M / F NV / C	_____	_____	_____ R/L
Child's age: _____ M / F NV / C	_____	_____	_____ R/L
Names of children:			

PERIODS

Date of Last period? _____ Menarche - Age of first menses (period): _____ years old.

Tell me about your period in the **last 12 months:**

- How many days do you bleed each month (fresh blood until spotting stops). Shortest: _____ longest: _____
- How often do you get your period (eg. Monthly, between 28 to 32 days). Shortest: _____ longest: _____
- **Describe your periods** (are they regular, normal flow, heavy, light, painful, spotting,): _____

_____

MEDICAL

Pain with intercourse? No ☐ Yes ☐ - Is there a history of endometriosis? _____

Do you suffer from: Acne? Yes ☐ Unwanted body hair? Yes ☐ Excess weight? Yes ☐ _____

Your comments _____

Past contraception methods: _____ When did you stop: _____

Your medical history or health concerns: _____

_____

_____

Anxiety or depression: No ☐ Yes ☐ _____

MEDICATIONS

Multivitamins: Do you take a multivitamin that contains folic acid and iodine? No/Yes – details _____

Medications: List all prescribed medications (include dose) and over-the- counter medications and supplements.

_____

_____

_____

Any Allergies (describe reaction): _____

_____

Other supplements & natural therapies. _____

_____

_____

SURGERY

Had surgery? No ☐ Yes ☐, (laparoscopy, hysteroscopy, curette, polypectomy, myomectomy, **OTHER**?)

Month/year _____**Surgery**: _____

Important findings: _____

Month/year _____**Surgery**: _____

Important findings: _____

Month/year _____**Surgery**: _____

Important findings: _____

When was the last time you had the **Measles Mumps Rubella vaccine**? _____ Never ☐

Date of last PAPSMEAR: _____ Have you ever had an abnormal result? No ☐ Yes ☐

Do you have breast lumps or had an abnormal mammogram or breast cancer? No ☐ Yes ☐

LIFESTYLE

Smoking history: Never ☐ Former ☐ When did you stop? _____

FOR CURRENT SMOKERS: ☐ Age started: _____ Quantity: _____ / day

Alcohol: No ☐ Yes ☐(amount and how often) _____

Recreational drugs: No ☐ Yes ☐ Marijuana ☐ Other ☐_____

Exercise: Never ☐ Occasionally ☐____ times/week Daily ☐

Diet: Well-balanced ☐ Fair ☐ Poor ☐

Diet restrictions? No ☐ Vegetarian ☐ Other ☐ _____

Caffeine Intake (coffee, teas, energy drinks, soda, etc.) ☐None ☐Yes, _____ cups/daily

FAMILY HISTORY

FAMILY HISTORY - Please indicate if there are medical or developmental problems among your BLOOD relatives and their children

Mother: _____

Father: _____

Brother or sister: _____

Brother or sister: _____

Other family: _____

*Please include early menopause, endometriosis, PCOS, heart disease, breast cancer (with age of diagnosis), hypertension, diabetes, osteoporosis, stroke, genetic disease, mental illness, arthritis, colon, kidney or thyroid disease and blood clotting problems.

End of Form. Thank you very much.

MALE history

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Endocrinologist & Fertility Specialist

My Fertility Care

GENERAL HEALTH

Today's date: _____

Your name: _____ Your Age _____

Partner's Name: _____

Best contact no: _____ Email address _____

Have you ever had a **sperm test**: No ☐ Yes ☐- When: _____ (*Please bring result)*

How many pregnancies have you fathered in this relationship: _____ in other relationships: _____

Medical history (General health + history of undescended testes, trauma, mumps, bladder, scrotal or prostate infection, erectile dysfunction etc) -:

_____

_____

_____

SURGERY

List surgery & treatment (including testicular surgery, hernia repair, vasectomy, chemotherapy, radiotherapy)

Month/year_____**Surgery**: _____

Important findings: _____

Month/year_____**Surgery**: _____

Important findings: _____

MEDICATIONS

Medications & Vitamins: List all prescribed medications and over-the- counter medications and supplements.

_____

_____

LIFESTYLE

Smoking history: Never ☐ Former ☐ When did you stop? _____

FOR CURRENT SMOKERS: ☐ Age started: _____ Quantity: _____ / day

Alcohol: No ☐ Yes ☐ (amount and how often) _____

Recreational drugs: No ☐ Yes ☐ Marijuana ☐ Other ☐_____

Anabolic Steroids: No ☐ Yes ☐- When? Duration? Protocol? Any side effects? Did you test your sperm prior to starting?

_____

_____

Exercise: Never ☐ Occasionally ☐____ times/week Daily ☐

Diet: Well-balanced ☐ Fair ☐ Poor ☐

Diet restrictions? No ☐ Vegetarian ☐ Other ☐_____

Caffeine Intake (coffee, teas, energy drinks, soda, etc.) ☐None ☐Yes, _____ cups/daily

FAMILY HISTORY

FAMILY HISTORY - Please indicate if there are medical or developmental problems among your BLOOD relatives and their children

Mother: _____

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End of Form. Thank you very much.