Herts & Essex Fertility Centre

Female Partner Health Questionnaire

NAME.....**D.O.B** .....

RELATIONSHIP HISTORY

How long have you been living together .....Years

How long have you been trying for a baby with present partner .....Years

How long have you tried for a baby with any previous partner(s) .....Years

How many times do you have intercourse per week ..... Week

PREVIOUS PREGNANCY HISTORY

Have you ever been pregnant before with: Previous partner Yes/No
Present partner Yes/No

If yes, do you have any children? Please state age of all children and delivery details e.g. Caesarean, Forceps, Ventouse

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What year was the last pregnancy .....

What year was the last delivery.....

Have you lost any pregnancy through the following:

	Naturally	IVF
Ectopic pregnancy	Yes/No	Yes/No
Miscarriage	Yes/No	Yes/No
Termination of pregnancy	Yes/No	Yes/No
Stillbirth	Yes/No	Yes/No
Prematurity	Yes/No	Yes/No

If yes to any, please give details

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MENSTRUAL HISTORY

At what age did you start your first period ……..

When was the first day of your most recent period …….....
(Day 1 is when there is fresh red blood)

How many days does your period last ..... days

How often do you get periods (from the 1st day to the next 1st day of period) .....days

Are your periods fairly regular? Yes/No
If not, how irregular? Range ……...……..

Are your periods painful? Yes/No

If yes when does the pain start in relation to the period ……

NON GYNAECOLOGICAL AND GYNAECOLOGICAL OPERATIONS

List all operations you have had in the past, which required a general anaesthetic and approximate date:

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Do you suffer and have you suffered from any of the following medical conditions:

Cardiovascular e.g. heart disease, raised blood pressure Yes/No

Respiratory e.g. asthma, bronchitis, tuberculosis Yes/No

Diabetes Yes/No

Thyroid disease Yes/No

MRSA (Including any close contact) Yes/No

If yes to any of the above, please give details

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DRUG HISTORY

Are you on any regular medications? If yes, please list:

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(It is recommended that you take folic ccid to reduce the risk of spina bifida)

Do you have any allergy to drugs? Yes/No
If yes, please give details

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Do you have any other allergies e.g. latex, Elastoplast? Yes/No
If yes, please give details

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GYNAECOLOGICAL INVESTIGATIONS/OPERATIONS

Have you had hormone tests? Yes/No

Have you had any Ultrasound Scans? Yes/No

Have you had any of the following tests to check your fallopian tubes?

1. HSG (Hysterosalpingogram - x-ray dye test) Yes/No
2. Laparoscopy/dye Yes/No

If yes, give details and date

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Have you been diagnosed with any of the following conditions?

Fibroid	Yes/No
Ovarian cyst	Yes/No
Endometriosis	Yes/No
Tubal damage	Yes/No
Polycystic ovaries	Yes/No
Pelvic adhesions	Yes/No
Pelvic infection	Yes/No
Abnormal cervical smear (cone biopsy or laser)	Yes/No

Appendicitis Yes/No

If yes to any of the above, please give details especially of any associated operations that have been carried out.

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GENERAL HEALTH

What is your height .....metres or ..... ft .....inches

What is your weight ..... kg or .....stone .....lbs

BMI = ... (to be calculated by clinic)

SOCIAL HISTORY

Do you smoke? Yes/No
If yes how many cigarettes per day .....

Do you drink? Yes/No
If yes how many units per week? .....

(1 Unit of Alcohol = 1 small glass of wine or ½ pint of beer)

Do you take recreational drug? ..... Yes/No

Are you immune to Rubella (German measles) ……..... Yes/No

If not immune it is recommended that you are vaccinated by your GP.

If you do not know please ask your GP who will do a blood test to check it out.

PREVIOUS FERTILITY TREATMENT

Have you had fertility tablets (Clomid or Tamoxifen) Yes/No

Have had IUI (Intra-Uterine Insemination) Yes/No

Have had IUI with Donor Sperm Yes/No

Have had IVF before Yes/No

Have you had ICSI before Yes/No

Have you had ovarian hyperstimulation after fertility treatment? Yes/No

If yes to any of the above, please list them below giving details of Fertility Centre, date, drugs used and dose, no. of eggs retrieved/fertilised, no. of embryos transferred, and outcome of treatment.

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IT IS IMPORTANT THAT YOU BRING WITH YOU, COPIES OF ANY MEDICAL REPORT AND RESULTS OF ANY PREVIOUS INVESTIGATIONS SUCH AS BLOOD TESTS AND SCANS/X-RAYS.

I confirm that the above information is an accurate record of my medical history from the date stated below.

Signed: ..... Date: .....

Reviewed: August 2017