Centre for Reproductive Immunology and Pregnancy

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?	☐ Miscarriage ☐ Failed IVF ☐ PCOS ☐ Fibroids ☐ Endometriosis ☐ Ectopic ☐ Delayed Fertility ☐ Stillbirth ☐ Male Fertility Factors	
Do you have a registered disability?	Yes No	If yes, please state ……..
Ethnicity		
Weight in **Kg:** **Stones & lbs:**	Height in **Cm:** **Feet & inches:**	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 **Kg:** **Stones & lbs:**	Height in **Cm:** **Feet & inches:**	BMI:

Centre for Reproductive Immunology and Pregnancy

Pre-Appointment History Sheet

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

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

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

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)

	1	**2**	**3**	**4**	**5**
Pregnancy Outcome 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
Year					
Type of conception Please circle	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation
Gestation miscarriage diagnosed at					
Type of Miscarriage i.e complete/missed **Gestation miscarriage size**					
Management of Miscarriage Please circle	Natural Surgery Tablets	Natural Surgery Tablets	Natural Surgery Tablets	Natural Surgery Tablets	Natural Surgery Tablets

Centre for Reproductive Immunology and Pregnancy

Pre-Appointment History Sheet

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

	1	**2**	**3**	**4**	**5**
Type of IVF Please circle	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor
IVF/ICSI					
Where IVF done					
Year					
Number of eggs collected					
Number of fertilised embryos					
Number of embryos or blastocysts transferred					
Outcome 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:

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

Pre-Appointment History Sheet

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

Please fill in table below with your medical history:

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

Pre-Appointment History Sheet

Please circle	No
Other medical issues	
Do you take any multivitamins while you are trying?	If Yes please provide the name of them below:
Have you had the Covid-19 vaccination?	If yes then please provide the name and date of vaccine: First dose – Second dose –
Has your partner had the Covid-19 vaccination?	If yes then please provide the name and date of vaccine: First dose – Second dose –

Please fill in table below with your family history:

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

Centre for Reproductive Immunology and Pregnancy

Pre-Appointment History Sheet

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

Full address:	
Contact number:	
Email address:	
Partner's number:	
Partner's email address:	

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

Name:	
Contact number:	

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

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

We ask if you could kindly send any relevant results or correspondence to us prior to your appointment, as unfortunately results bought 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.