



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 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:	



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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>Fresh</u> <u>Frozen</u> <u>Donor</u>	<u>Ectopic/Pregnancy of unknown location</u>	<u>Stimulated Cycles & medication used</u> (i.e. Letrozole/Clomid)	<u>Stillbirths</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>
<u>Pregnancy Outcome</u> 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
<u>Month and Year</u>					
<u>Type of conception</u> Please circle	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation
<u>Gestation miscarriage diagnosed at</u>					
<u>Type of Miscarriage</u> i.e complete/missed <u>Gestation miscarriage size</u>					
<u>Management of Miscarriage</u> 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>
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					
Month and Year					
Number of eggs collected					
Number of fertilised embryos					
Number of embryos or blastocysts transferred					
Outcome Please circle	Child Pregnancy loss Ectopic Failed attempt	Child Pregnancy loss Ectopic Failed attempt	Child Pregnancy loss Ectopic Failed attempt	Child Pregnancy loss Ectopic Failed attempt	Child Pregnancy loss Ectopic 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



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<p><u>Have you had any of the following investigations and if so in what year:</u> Please circle</p>	<p>Hysteroscopy Laparoscopy HyFosy HSG</p>
<p><u>Are you up to date with your cervical smears?</u> Please circle</p>	<p>Yes No</p>
<p><u>Have you ever had an abnormal smear?</u> Please circle</p>	<p>Yes No If yes in which year If yes how was it treated?</p>
<p><u>Have you ever had female genital mutilation?</u> Please circle</p>	<p>Yes No If yes in which year</p>

Please fill in table below with your medical history:

<p><u>Do you have any medical history of:</u></p>	
<p><u>Diabetes</u> Please circle</p>	<p>Yes: Type I Type II No</p>
<p><u>High Blood Pressure</u> Please circle</p>	<p>Yes No</p>
<p><u>Glaucoma</u> Please circle</p>	<p>Yes No</p>
<p><u>Thyroid</u> Please circle</p>	<p>Yes No</p>
<p><u>Asthma</u> Please circle</p>	<p>Yes</p>



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	No
Recurrent miscarriages Please circle and if yes who?	Yes - No
Other family history	

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 email address		



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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.