**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?<br>(please circle) | Yes<br>No | If yes, how many per day? ……. |
| How is your alcohol intake?<br>(please circle) | None Low Moderate High | |
| Are you on any regular medications? | | |
| Do you have any allergies? | Yes<br>No | Allergies: |
| What do you consider your main issue? | ☐ Miscarriage ☐ Failed IVF ☐ PCOS ☐ Fibroids ☐ Endometriosis<br>☐ Ectopic ☐ Delayed Fertility ☐ Stillbirth ☐ Male Fertility Factors | |
| Do you have a registered disability? | Yes<br>No | If yes, please state …….. |
| Ethnicity | | |
| Weight in **Kg:**<br>**Stones & lbs:** | Height in **Cm:**<br>**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?<br>(please circle) | Yes<br>No | If yes, how many per day? ……. |
| How is your alcohol intake?<br>(please circle) | None Low Moderate High | |
| Are you on any regular medications? | | |
| Do you have any children from a previous relationship? | Yes<br>No | If yes: how many, sex and what ages? |
| Do you have any allergies? | Yes<br>No | Allergies: |
| Do you have a registered disability? | Yes<br>No | If yes, please state …….. |
| Ethnicity | | |
| Weight **Kg:**<br>**Stones & lbs:** | Height in **Cm:**<br>**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:

| **Children**<br><br>(Sex, Age, Name, Weight and delivery mode) | **Miscarriages and/or chemical pregnancies** | **IVF/ICSI** | **Ectopic/Pregnancy of unknown location** | **Stimulated Cycles & medication used**<br><br>(i.e. Letrozole/Clomid) | **Stillbirths** |
|---|---|---|---|---|---|
| | | **Fresh**<br><br>**Frozen**<br><br>**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**<br>Please circle | Miscarriage<br>Chemical pregnancy<br>Ectopic<br>Second Trimester loss<br>Child | Miscarriage<br>Chemical pregnancy<br>Ectopic<br>Second Trimester loss<br>Child | Miscarriage<br>Chemical pregnancy<br>Ectopic<br>Second Trimester loss<br>Child | Miscarriage<br>Chemical pregnancy<br>Ectopic<br>Second Trimester loss<br>Child | Miscarriage<br>Chemical pregnancy<br>Ectopic<br>Second Trimester loss<br>Child |
| **Month and Year** | | | | | |
| **Type of conception**<br>Please circle | Natural<br>IVF/ICSI<br>Superovulation | Natural<br>IVF/ICSI<br>Superovulation | Natural<br>IVF/ICSI<br>Superovulation | Natural<br>IVF/ICSI<br>Superovulation | Natural<br>IVF/ICSI<br>Superovulation |
| **Gestation miscarriage diagnosed at** | | | | | |
| **Type of Miscarriage** i.e complete/missed<br><br>**Gestation miscarriage size** | | | | | |
| **Management of Miscarriage**<br>Please circle | Natural<br>Surgery<br>Tablets | Natural<br>Surgery<br>Tablets | Natural<br>Surgery<br>Tablets | Natural<br>Surgery<br>Tablets | Natural<br>Surgery<br>Tablets |

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

| | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Type of IVF**<br>Please circle | Fresh<br>Frozen<br>Donor | Fresh<br>Frozen<br>Donor | Fresh<br>Frozen<br>Donor | Fresh<br>Frozen<br>Donor | Fresh<br>Frozen<br>Donor |
| **IVF/ICSI** | | | | | |
| **Where IVF done** | | | | | |
| **Month and Year** | | | | | |
| **Number of eggs collected** | | | | | |
| **Number of fertilised embryos** | | | | | |
| **Number of embryos or blastocysts transferred** | | | | | |
| **Outcome**<br>Please circle | Child<br>Pregnancy loss<br>Ectopic<br>Failed attempt | Child<br>Pregnancy loss<br>Ectopic<br>Failed attempt | Child<br>Pregnancy loss<br>Ectopic<br>Failed attempt | Child<br>Pregnancy loss<br>Ectopic<br>Failed attempt | Child<br>Pregnancy loss<br>Ectopic<br>Failed attempt |

Please fill in table below with your gynaecological history:

| | |
|---|---|
| **Cycle length** | |
| **Number of days of bleeding** | |
| **Blood Loss**<br>Please circle | Light Average Heavy |
| **Last Menstrual Period**<br>(Please leave blank for Mr Shehata to fill in) | |
| **Do you get any bleeding between periods?**<br>Please circle | Yes<br><br>No |
| **Do you get any bleeding after intercourse?**<br>Please circle | Yes<br><br>No |
| **Do you get any pain during intercourse?**<br>Please circle | Yes<br><br>No |

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| | |
|---|---|
| **Have you had any of the following investigations and if so in what year:**<br>Please circle | Hysteroscopy<br>Laparoscopy<br>HyFosy<br>HSG |
| **Are you up to date with your cervical smears?**<br>Please circle | Yes<br>No |
| **Have you ever had an abnormal smear?**<br>Please circle | Yes<br>No<br>If yes in which year ……<br>If yes how was it treated? …….. |

Please fill in table below with your medical history:

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

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| | |
|---|---|
| Please circle | No |
| **Cardiac Abnormalities**<br>*i.e. palpitations*<br><br>Please circle | Yes<br><br>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?**<br>If yes, please circle which vaccine:<br><br>Pfizer AstraZeneca Moderna | If yes then please provide the date of vaccine:<br><br>First dose –<br>Second dose –<br>Booster - |
| **Has your partner had the Covid-19 vaccination?**<br>If yes, please circle which vaccine:<br><br>Pfizer AstraZeneca Moderna | If yes then please provide the date of vaccine:<br><br>First dose –<br>Second dose –<br>Booster - |

Please fill in table below with your family history:

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

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| | |
|---|---|
| | 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** | |

**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.**