PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

FEMALE PATIENT NAME; --

MAIDEN NAME (If Applicable) --

FULL POSTAL ADDRESS; --

DATE OF BIRTH; --

NATIONALITY: --

PPS NUMBER; --

DPS NUMBER ; (if applicable) --

TELEPHONE NO's:

Home: -------------------------------- Work (or 9-5pm): ------------------------------ Mobile: --------------------------------

OK to Leave message (please tick):

Home □ Work (or 9-5pm) □ Mobile □

PERSONAL EMAIL ADDRESS; --

OCCUPATION; --

ALLERGIES: --

GP NAME: --

GP ADDRESS; Full Postal Address: --

Did you have a medical Referral to this clinic? Yes □ No □

If so, please state name of referring Doctor: --

If you were not referred by a doctor, please state how you heard of Sims Clinic;

FRIEND: --------------------------------------- RELATIVE: ------------------------------------

NEWSPAPER: -- RADIO: ---------------------------------------

INTERNET: --- T.V: ---

DO YOU HAVE HEALTH INSURANCE? (Please CIRCLE) YES NO
(If you answered "YES" to the above question, please complete this section)

INSURANCE CO. (VHI/ QUINN/ VIVSA/ OTHER) ---

NAME OF SUBSCRIBER; --

MEMBERSHIP NO. --- PLAN------------------------------------

Your records are considered confidential and will not be released without your consent and signature.

Please sign the release below:
I hereby authorise the Sims Fertility Clinic to release information to my GP and myself.

PATIENT SIGNATURE: --- DATE: ---------------------------

I have been given the SIMS Fertility Clinic booklet and I will take time to read the relevant sections including that on complications associated with IVF.

______________________________ ______________________

Signed (Female Patient) Date

PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

PARTNER'S NAME: -- SEX: [ ]

DATE OF BIRTH: ---------------------------------

NATIONALITY: -------------------------------------

TELEPHONE NO's:

Home: -------------------------------- Work (or 9-5pm): ------------------------------- Mobile: --------------------------------

OK to Leave message (please tick):
Home □ Work (or 9-5pm) □ Mobile □

PERSONAL EMAIL ADDRESS; ---

OCCUPATION; --

ALLERGIES: ---

GP NAME: ---

GP ADDRESS; Full Postal Address: --

Your records are considered confidential and will not be released without your consent and signature.

Please sign the release below:
I hereby authorise the Sims Fertility Clinic to release information to my GP and myself.

PATIENT SIGNATURE: --- DATE: ----------------------------

I have been given the SIMS Fertility Clinic booklet and I will take time to read the relevant sections including that on complications associated with IVF.

______________________________ ______________________________
Signed (Male Patient) Date

PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

Female Patient Medical History

How long have you been trying to conceive? ___________________________________

Have you had previous fertility treatment? If so, where and when did this take place?

____
____
____
____
____

Gynaecologic/Obstetric Summary

If you have been pregnant before, please fill out the table below.

Your age	Sex/age of child	Duration of pregnancy	Complications/healthy?

Do you have any pregnancies from a previous relationship?____

Do you suffer from endometriosis? ____

Do you suffer from PCOS (polycystic ovaries)? ____

Have you suffered from any gynaecologic condition? ____

Are you or have you attended a gynaecologist in the past? ____

When was your last smear test? ____

At what age did you get your first period? ____

How often do your periods come and how long do they generally last?

____

Are your periods excessively heavy or painful? If they are painful, what painkillers do you take?

____
____

Do you get clots with your period? ____

Do you use a pad or a tampon or both? ____

What is the date of the first day of your last period? ____

Do you get mid-cycle discomfort or vaginal mucus at your fertile time (ovulation)? __________________________

Do you have any pain during sex, or bleeding in between your periods, or bleeding after sex?

____

Are you currently on any medications?

____
____
____

Are you attending a medical doctor or being treated for an illness or medical condition? (Please supply details of illnesses you may have been treated for in the past).

____
____
____
____

Have you ever undergone an operation? (If so, please give details).

____
____
____

Have you been treated for an STD (Sexually Transmitted Disease)?

____
____

How many units of alcohol do you consume per week? (1 pint = 2 units) ____________________

Do you smoke? If so, how many per week? ____________________

If you are no longer a smoker, when did you give up smoking? ____________________

What contraceptives have you used in the past?

Type	When	Duration

Has a member of you immediate family died from a chronic illness or disease?

____
____
____
____

Are there any significant inherited diseases in your family that you are aware of? e.g. heart disease, diabetes, cystic fibrosis etc. ____________________

Do you have any other general medical complaints at present?

____

Do you have any concerns about your sexual life?

____

PLEASE COMPLETE THE FOLLOWING FORM USING BLOCK CAPITALS

Male Partner Medical History (IF APPLICABLE)

Are you currently on any medications?

____

____

____

Are you attending a medical doctor or being treated for an illness or medical condition? (Please supply details of any illnesses you may have been treated for in the past).

____

____

____

____

Have you ever undergone an operation? (If so, please give details).

____

____

____

Have you been treated for an STD (Sexually Transmitted Disease)?

____

____

How many units of alcohol do you consume per week? (1 pint = 2 units) ________________

Do you smoke? If yes, how many per week? ________________________________

If you are no longer a smoker, when did you give up smoking? ____________________

Has a member of you immediate family died from a chronic illness or disease?

____

____

Are there any significant inherited diseases in your family that you are aware of? e.g. heart disease, diabetes, cystic fibrosis etc. ____

Do you have any other general medical complaints at present? ______________________________

Have you ever experienced a groin injury? ______________________________________

Do you have undescended testicles? ____

Did you ever have mumps either as a child or an adult? ___________________________

Have you had a semen analysis carried out? ______________________________________

If yes, was it normal? If not, please describe any abnormalities found

____

____

Do you have any pregnancies from a previous relationship?_____________________________

Do you have any concerns about your sexual life?

____