

PERSONAL HEALTH QUESTIONNAIRE

This questionnaire has been designed to help ensure your health records are accurate and up to date.
Please bring the completed form with you to your initial doctor consultation or forward prior to your visit.

FEMALE PARTNER DETAILS

Preferred Title

Mrs Ms Miss Dr Other:

LAST NAME:

FIRST NAME(s)

DATE OF BIRTH:

CONTACT DETAILS:

.....Postcode

Phone:(H)(W)

Mobile

Email:

Occupation:

MALE PARTNER DETAILS

Preferred Title

Mr Dr Ms Other :

LAST NAME:

FIRST NAME(s)

DATE OF BIRTH:

CONTACT DETAILS:

.....Postcode

Phone:(H)(W)

Mobile

Email:

Occupation:

Your Referring Doctor (if applicable)

Your Family Doctor as above OR

(Tick here if you would like us to keep your family doctor (or other health professional listed above) up to date with the progress of your treatment)

YOUR CURRENT RELATIONSHIP

1.	How long have you been trying to have children in your present relationship?	Year(s)	Month(s)
2.	Have you ever been pregnant with your current partner? <i>(including any miscarriages or pregnancies which were terminated)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<i>If YES, please provide details in the table below</i>	

*Details of any previous pregnancies with current partner.
For each pregnancy, please fill in the year of the pregnancy and tick the appropriate box.*

Year/Month of Pregnancy	Live Birth (✓)	Miscarriage (✓)	Termination (✓)	Ectopic Pregnancy (✓)	Comments (eg the results of any fertility treatment)

3.	How many times do you have intercourse per month: <i>times per month</i>	
4.	Are there any difficulties with intercourse?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you had any previous treatment for infertility in this relationship?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PREVIOUS RELATIONSHIPS

6.	Have you ever been pregnant with a previous partner? (Including any miscarriages or pregnancies which were terminated)	Female: <input type="checkbox"/> YES <input type="checkbox"/> NO Male: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please provide details in the table below</i>
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OUTCOME OF PREGNANCY

Year/Month of Pregnancy Male (M) / Female (F) Partner	Live Birth (✓)	Miscarriage (✓)	Termination (✓)	Ectopic Pregnancy (✓)	Comments (eg the results of any fertility treatment, RH factor issues)

7.	Did you need any treatment for infertility in your previous relationship?	Female: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>Name of Doctor:</i> <i>Treatment:</i> Male: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>Name of Doctor:</i> <i>Treatment:</i>
8.	Do you have any known allergies to drugs, antibiotics, sticking plaster, iodine or food? <i>If YES, please provide details:</i>	Female: <input type="checkbox"/> YES <input type="checkbox"/> NO Male: <input type="checkbox"/> YES <input type="checkbox"/> NO
9.	Have you or your family ever had a reaction to anaesthetic drugs? <i>If YES, please provide details:</i>	Female: <input type="checkbox"/> YES <input type="checkbox"/> NO Male: <input type="checkbox"/> YES <input type="checkbox"/> NO
10.	Do you use any complementary therapies (e.g. acupuncture, herbal remedies, vitamins, naturopathy)? <i>If YES, please list all therapies and if currently undertaking treatment</i>	Female: <input type="checkbox"/> YES <input type="checkbox"/> NO Male: <input type="checkbox"/> YES <input type="checkbox"/> NO
11.	<i>Female only:</i> Have you been taking at least 500 micrograms (mcg) of Folate (folic acid) per day for at least three months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
12.	<i>Female only:</i> Have you been immunised for Rubella?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, when:</i>
13.	<i>Female only:</i> Have you had a PAP smear and breast examination in the last two years?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>Date of last PAP smear .../.../....</i> <i>Date of last breast exam: .../.../....</i>

SIGNED DATE/...../.....
MALE PARTNER

SIGNED DATE/...../.....
FEMALE PARTNER

.....
Please print full name above

.....
Please print full name above

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY QUESTIONNAIRE

FEMALE PARTNER

YOUR GENERAL HEALTH

1.	Is your general health good?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Are you currently being treated for an illness: <i>If YES, please provide details in the table below</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

NATURE OF ILLNESS	DATE	TREATMENT

3.	Have you had any significant condition in the past, e.g. diabetes, heart disease, asthma, epilepsy, kidney disease, migraine, cancer? <i>If YES, please provide details in the table below</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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NATURE OF ILLNESS	DATE	TREATMENT

4.	Do you take any tablets, medicine or drugs on a regular basis? <i>If YES, please provide details in the table below</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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NATURE OF ILLNESS	DATE	TREATMENT (i.e., tablets, medicine)

5.	Is there a family history of illness; in particular, breast or ovarian cancer, endometriosis, cystic fibrosis, genetic diseases, autoimmune diseases, blood clots, early onset heart attack, pregnancy loss, preterm delivery or fertility problems? <i>If YES, please provide details:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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LIFESTYLE

6.	Have you ever smoked cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, how many cigarettes do you have per week? When did you stop?</i>
7.	Do you smoke marijuana or take drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, how frequently do you smoke or use?</i>
8.	Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, how many standard drinks do you have per day? eg wine (125mls), beer (285mls), spirits (nips)</i>

FEMALE PARTNER (cont)

9.	Do you consume coffee, cola drinks, tea, energy drinks or chocolate?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, please list the items and quantities consumed per day</i>
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10.	Have you ever had any of the following:	<input type="checkbox"/> YES <input type="checkbox"/> NO	DETAILS	DATES
a)	<i>Pelvic Inflammation</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
b)	<i>Sexually Transmitted Infection</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		

11.	Have you ever had any of the following operations?		DETAILS	DATES
a)	<i>Laser treatment, diathermy or Cryosurgery to the cervix for an abnormal Pap smear</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
b)	<i>Caesarean Section</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
c)	<i>Removal of a fibroid</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
d)	<i>Curettage of the Uterus (D&C)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
e)	<i>Operation on an Ovary</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
f)	<i>Operation on a Fallopian Tube</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
g)	<i>Sterilisation</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
h)	<i>Removal of Appendix</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
i)	<i>Any other Surgery</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Describe any anaesthetic problems with any of the above

12.	Have you ever had:		DETAILS	DATES
a)	<i>An X-ray (hysteroqram) of the uterus</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
b)	<i>A laparoscopy</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		

13.	How long do your periods usually last?days
14.	Do you have any pain with your periods?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<i>If YES, how severe is the pain?</i>
15.	Has your weight changed a lot in the last year?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<i>If YES, by how much?</i>Kgs gained or lost

FEMALE PARTNER (cont)

SCREENING FOR INFECTIOUS DISEASE

I understand that Repromed is required to screen both partners for infectious diseases. In case of a positive result early medical intervention can significantly reduce the risk of transmission to the child. I understand blood tests for hepatitis B & C and HIV (AIDS) will be ordered if we pursue treatment.

Pre test counselling is a requirement prior to testing for any infectious diseases. You may have been exposed to infections if you have been sexually active, had a blood transfusion, body piercing or a history of intravenous drug use.

Confidentiality

Under the Repromed Privacy Policy patients have a right to be dealt with in confidence, provided it is lawful and practicable. Results of infectious disease tests will be available at your next routine appointment. Results are not given out over the phone. Initially if a test returns positive, Repromed will enable this result to be given to you individually but in the interests of medical safety of partners we would like to discuss the implications of a positive result with both partners. It should be noted that false positives are not uncommon and specific testing will always be done to confirm the actual result.

On confirmation of a positive result your doctor will discuss the immediate implications and support services available and will refer you to a specialist infectious diseases clinic for appropriate management and counselling. Repromed doctors and counsellors will be available on an ongoing basis to discuss any concerns as well as fertility options.

Any confirmed positive result is a notifiable disease and all sexual partners will ultimately be contacted by the relevant government department. HIV infected people are legally required to inform their partner of their status. Testing for these diseases may have implications for insurance or employment related medical examinations.

I CONFIRM and AGREE

- I have read and understood the above information on infectious disease testing by Repromed.
- I confirm that the information I have given in this form is accurate, complete and up to date.
- I agree to have blood tests for infectious diseases if I decide to go ahead with treatment.
- I am aware of the implications and legal requirements of this testing.
- I agree to Repromed discussing the implications of a positive result with my partner.

SIGNED:.....
FEMALE PARTNER

DATE:/...../.....

.....
Please print your full name above

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY QUESTIONNAIRE

MALE / PARTNER

YOUR GENERAL HEALTH

1.	Is your general health good?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Are you currently being treated for an illness: <i>If YES, please provide details in the table below</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

NATURE OF ILLNESS	DATE	TREATMENT

3.	Have you had any significant condition in the page, eg diabetes, heart disease, asthma, epilepsy, kidney disease, migraine, cancer? <i>If YES, please provide details in the table below</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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NATURE OF ILLNESS	DATE	TREATMENT

4.	Do you take any tablets, medicine or drugs on a regular basis? <i>If YES, please provide details in the table below</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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NATURE OF ILLNESS	DATE	TREATMENT (i.e., tablets, medicine)

5.	Do you have any known allergies to drugs, antibiotics, sticking plaster, iodine or food? <i>If YES, please provide details:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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6.	Have you ever had mumps? <i>If YES, please tick the appropriate boxes to show when/how you were affected:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<input type="checkbox"/> As a child <input type="checkbox"/> After puberty at age		
	<input type="checkbox"/> Symptoms include testicular pain and swelling		

7.	Have you ever had any of the following operations?		DETAILS	DATES
a)	Hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO		
b)	Hydrocele (water on testicle)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
c)	Disorder of the penis	<input type="checkbox"/> YES <input type="checkbox"/> NO		
d)	Varicocele (varicose veins around the testicle)	<input type="checkbox"/> YES <input type="checkbox"/> NO		

MALE / PARTNER (cont)

Have you ever had any of the following operations (cont)?			
e)	<i>Testicular biopsy</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	
f)	<i>Vasectomy</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	
g)	<i>Reversal of vasectomy</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	
h)	<i>Any other Surgery</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	

Describe any anaesthetic problems with any of the above

8.	Have you ever had undescended testicle? <i>If YES, please provide details of treatment including the age when you had treatment</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Have you ever been admitted to hospital (other than for the operations listed in Question 7?) As a child? <i>If so, what for?</i> As an adult? <i>If so, what for?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO

10.	Have you ever had any of the following?		DETAILS	DATES
a)	<i>Chronic pain in the testicles</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
b)	<i>Swelling of the testicles</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
c)	<i>Injury to the testicles</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
d)	<i>A dragging feeling in the scrotum</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
e)	<i>Pain on passing urine</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
f)	<i>Blood in the urine</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
g)	<i>Pus in the urine</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
h)	<i>A need to get out of bed at night to pass urine</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
i)	<i>Sexually Transmitted Infection</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO		

11.	Is there a family history of illness; in particular fertility problems, pregnancy loss, preterm births, blood clots, early onset heart attack, genetic diseases, autoimmune diseases or cystic fibrosis? <i>If YES, please provide details:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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12.	Have you ever been exposed to any of the following?		DETAILS	DATES
a)	Toxic chemicals (eg lead)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
b)	Radiation (apart from medical X-rays)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
c)	Hot working conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO		

LIFESTYLE

13.	Have you ever smoked cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, how many cigarettes do you have per week? When did you stop?</i>
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15.	Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, how many standard drinks do you have per day? eg wine (125mls), beer (285mls), spirits (nips)</i>
16.	Do you consume coffee, cola drinks, tea, energy drinks or chocolate?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If YES, please list the items and quantities consumed per day</i>
17.	Please add any other comments which you think are relevant to your situation:		

MALE / PARTNER (cont)

SCREENING FOR INFECTIOUS DISEASE

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- I agree to Repromed discussing the implications of a positive result with my partner.

SIGNED:.....
MALE PARTNER

DATE:/...../.....

.....
Please print your full name above

FOR CLINICAL STAFF TO COMPLETE:

FURTHER HISTORY:

EXAMINATION:

INVESTIGATIONS ORDERED: