

Please complete the following form and bring it with you to your initial consultation.

Fertility History

What is your date of birth?.....

How long have you been trying to conceive?.....

Do you have any children?.....

What is the duration of your relationship with your current partner?.....

Have you had any of the following?	Yes	No
Endometriosis		
PCOS		
Treatment to the cervix		
STD		

Have you had any of the following tests carried out?	Yes	No
Tubal/HSG		
Antisperm antibodies		
Laparoscopy		
Hormone tests - Progesterone/LH/FSH/Oestradiol		
Ultrasound		

Have you had a thyroid function test?

(Please bring any results of tests you have had with you to your initial consultation.)

What contraception have you used in the past?..... How long?.....

Previous Fertility Treatment	Yes	No
Clomid		
Cyclophene		
Tamoxifen		
Metformin		
IUI Cycles		
IVF Cycles		



Your Partner	Yes	No
Has your partner had a sperm test?		
History of STD?		
Hernia?		
Varicocoele?		

Partner's of sperm tests (if known)	
Count	
Motility	
Morphology	
Abnormal Heads	

(Please bring results with you to your initial consultation)