



Infertility Treatment
Endometriosis
Laparoscopic Surgery
Reproductive Microsurgery

Epworth Private Hospital
Suite 9.3, Level 9, 89 Bridge Road
Richmond, Victoria, 3121

Phone (03) 9516 2897
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Provider 209245FW

Confidential Patient Information - Female

By answering the following questions as accurately as possible, you help us get a better understanding of the problems that may influence your fertility. Take your time and read all the questions carefully. Give the completed questionnaire to your doctor.

Family Name: _____ First Name: _____

Date of Birth: _____

Specific questions for the female partner:

Life style Weight (kg): _____ Height (cm): _____

Have you lost or gained a lot of weight recently? Yes No

Do you smoke? Yes No How many cigarettes per day? _____

Do you drink alcohol? Regularly Rarely Never

Do you come in contact with harmful substances in your work place: Yes No

Pregnancy Have you ever been pregnant? Yes No If yes, when was your last pregnancy? _____

If yes, specify how many pregnancies you have had in this table:

	Current Partner	Previous Partner(s)
Miscarriages		
Terminations of pregnancy		
Ectopic pregnancies (eg. in the tube)		
Live births		

If no, for how many months have you been trying to get pregnant? _____

Have you ever received infertility treatment? Yes No

• If yes, specify: _____

Have you ever used contraception? Yes No

• If yes, specify: Contraceptive pill Condoms Intrauterine device Other

How old were you when you had your first period? _____ years old.

How long is your cycle? (from the 1st day of your period until the 1st day of your next period): _____ to _____ days.

How many days does your period last? (from the 1st day until the last day of your period): _____

Is your period very painful? Yes No

Do you feel that the amount of blood loss is abnormal? Yes No

Do you have a lot of symptoms prior to your period? Yes No

Is there vaginal blood loss between your periods? Yes No

Other rooms



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Confidential Patient Information - Female

Is intercourse painful? Yes No Do you sometimes use a lubricant? Yes No

Do you sometimes notice semen leaking from the vagina after intercourse? Yes No

How often do you have intercourse per month? More than 8x 4-8x 1-4x Rarely

Have you ever had an operation? Yes No

- If yes, have you ever had a:
 - caesarean section: Yes No
 - operation on the cervix: Yes No
 - laparoscopy (telescope through belly-button): Yes No
 - gynaecological operation via abdominal incision: Yes No
 - operation on the bowel (such as appendectomy): Yes No

When did you have your last PAP smear? _____

Have you ever been treated for one of the following illnesses? diabetes: Yes No

thyroid disease: Yes No

tuberculosis: Yes No

Have you ever been hospitalised for an illness? Yes No

• If yes, specify: _____

Are you currently under any form of treatment? Yes No

• If yes, specify: _____

Do you have any diseases that run in the family? Yes No

Are you on regular medication and if yes which? _____

Do you have any allergies (medications, food ...)? _____

Has anyone in your family ever had a deep venous thrombosis (DVT)? Yes No

Has anyone in your family ever had a pulmonary embolus (blood clot in the lungs)? Yes No

Personal remarks: _____

I declare the above information to be complete and correct.

Signature: _____ Date: _____

Other rooms

Suite 3, 252 Clayton Road
Clayton, Victoria, 3168

Level M, 233 Collins Street
Melbourne, Victoria, 3000

9 Hastings Street
Frankston, Victoria, 3199

Suite 8, 262 Main Street
Mornington, Victoria, 3931

8 Brettoneux Street
Seymour, Victoria, 3660