PROF LUK ROMBAUTS

MD PhD FRANZCOG CREI

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
Fax (03) 9421 5932
Pager (03) 9387 1000
Email info@lukrombauts.com.au
Web www.lukrombauts.com.au
Provider 209245FW

Confidential Patient Information - Registration Form

PERSONAL DETAILS

Family Name: _____ **First Name:** _____

Maiden Name: _____ **Date of Birth:** _____

Occupation: _____

Mailing Address: _____

Suburb: _____ **Postcode:** _____

Mobile: _____ **Email:** _____

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Fund: _____ **Membership Number:** _____

PARTNER DETAILS (if applicable)

Family Name: _____ **First Name:** _____

Maiden Name: _____ **Date of Birth:** _____

Occupation: _____

Mailing Address: _____

Suburb: _____ **Postcode:** _____

Mobile: _____ **Email:** _____

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Fund: _____ **Membership Number:** _____

REFERRING DOCTOR

Name: _____

Address: _____

_____

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
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Privacy Statement

As a patient of Prof. Luk Rombauts, a medical record containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details.

During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation.

If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request.

I hereby agree to the storage and the use of my medical information as outlined above.

Print Name: _____

Signature: _____

Date: _____

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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 ☐ Intrautrine 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

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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:** _____

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Confidential Patient Information - Male

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.

Surname and given name: _____ **First Name:** _____

Specific questions for the male 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

Have you ever been treated for one of the following illnesses?

diabetes:	☐ Yes ☐ No
thyroid disease:	☐ Yes ☐ No
liver or kidney disease:	☐ Yes ☐ No
chronic lung disease:	☐ Yes ☐ No

Do you know of people in your family who have an inherited condition? ☐ Yes ☐ No

Have you ever had an operation? ☐ Yes ☐ No

- If yes, have you ever had a:

operation on one or both testicles:	☐ Yes ☐ No
vasectomy:	☐ Yes ☐ No
operation on the bladder:	☐ Yes ☐ No
prostate operation:	☐ Yes ☐ No
operation on the penis:	☐ Yes ☐ No
inguinal hernia repair:	☐ Yes ☐ No
operation on your spinal cord:	☐ Yes ☐ No

Have you ever had mumps? ☐ Yes ☐ No At what age? _____

Have you ever experienced severe pain in one or both testicles? ☐ Yes ☐ No

Have you ever been treated for an undescended testicle? ☐ Yes ☐ No

Have you ever been treated for a urinary infection? ☐ Yes ☐ No

Have you ever had problems with erection or ejaculation? ☐ Yes ☐ No

If you have had other partners, was one of them ever pregnant? ☐ Yes ☐ No

Are you on regular medication and if yes which? _____

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

Personal remarks: _____

_____

I declare the above information to be complete and correct.

Signature: _____ **Date:** _____

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