REGISTRATION FORM

PLEASE COMPLETE BOTH SIDES OF REGISTRATION FORM

Title:

Surname:

First name: Middle name:

Preferred name: Former name:

Address:

Date of Birth: ____ / ____ / ____

Gender at Birth: ☐ Female ☐ Male ☐ X

Identify as: ☐ Female ☐ Male ☐ Other

Comments:

State: Postcode:

Mobile: Home Phone: Work Phone:

Email: Preferred method of communication:

Occupation: Do you have regular exposure to chemicals/pesticides/radiation ☐ Yes ☐ No

Nationality: Country of Birth:

Do you require an interpreter: ☐ Yes ☐ No If yes, which language:

Do you have a disability: ☐ Yes ☐ No If yes, please specify:

Are you vision impaired: ☐ Yes ☐ No Are you hearing impaired: ☐ Yes ☐ No

Partners full name *(if applicable)*: **Date of Birth:** ____ / ____ / _____

ACCOUNTS & REFERRALS

Do you have a current Medicare Card: ☐ Yes ☐ No

Medicare number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ Position number on card:

Medicare card valid to: /

Private Health Fund: Joined: / /

Membership number: Are you covered for IVF: ☐ Yes ☐ No

GP Name: **Clinic:**

Address:

Referring Doctor (if GP did not provide referral):

Your Care Fertility Specialist: ☐ Dr Boothroyd ☐ Dr Cattanach ☐ Dr Law ☐ Dr Armstrong

PREVIOUS FERTILITY TREATMENT

Type of cycle: No.of cycles: Clinic:

Do you have frozen eggs or embryos in cryostorage at another clinic: ☐ Yes ☐ No If 'yes' how many:

GYNAECOLOGICAL & OBSTETRIC HISTORY

How long have you been trying to fall pregnant: *months* Have you had an AMH blood test: ☐ Yes ☐ No

Usual cycle length: *days* **OR** is your cycle: ☐ Irregular ☐ Absent If applicable, how many cycles per year:

Have you been diagnosed with: ☐ Endometriosis ☐ Polycystic ovaries ☐ Tubal issues ☐ Pelvic inflammatory disease

When was your last PAP smear: Where was this taken: Have you had an abnormal PAP result: ☐ Yes ☐ No

Have you had a formal pelvic ultrasound scan: ☐ Yes ☐ No

Have you had a sexually transmitted infection: ☐ Yes ☐ No If 'yes' please record:

Please record any gynaecological surgeries:

CARE FERTILITY

CURRENT relationship: No. of children No. of pregnancies

No. of miscarriages No. of stillbirths No. of terminations No. of ectopics

PREVIOUS relationship/s: No. of children No. of pregnancies

No. of miscarriages No. of stillbirths No. of terminations No. of ectopics

MEDICAL HISTORY

Do you have: ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Blood type: Rh Negative: ☐ Yes ☐ No

Other **CURRENT** or **PAST** medical conditions:

Have you had chemotherapy or radiation: ☐ Yes ☐ No If 'yes' please record:

Please provide details **CURRENT** or **PAST** mental health issues:

Please record any general surgeries:

Did you have an anaesthetic reaction: ☐ Yes ☐ No / Nil known If 'yes' please record:

Do you have any medication allergies: ☐ Yes ☐ No If 'yes' please record:

Do you have a latex sensitivity/allergy: ☐ Yes ☐ No Do you have any other allergies: ☐ Yes ☐ No

Please record any prescription medication you are taking:

Please record any supplements or herbal remedies you are taking:

Folate 5mg /500mcg daily: ☐ Yes ☐ No Iodine 150mcg daily: ☐ Yes ☐ No

Fish oil / Aspirin ☐ Yes ☐ No *(discuss with nurse if 'yes')* Vitamin D: ☐ Yes ☐ No

Pregnancy multi: ☐ Yes ☐ No If 'yes' brand name:

FAMILY HISTORY

Is there a family history (more than one person) of Cancer: ☐ Yes ☐ No

If 'yes' what type of cancer: If 'yes' what relation is the person/s to you:

Do you have a genetically inherited condition: ☐ Yes ☐ No If 'yes' please record:

Is there a family history of any genetic disorders: ☐ Yes ☐ No

If 'yes' please record:

LIFESTYLE

Height: *cm*	**Weight:** *kg*	*Staff use: BMI*

Do you smoke tobacco: ☐ Yes, frequency: ☐ No If 'no', have you ever smoked ☐ Yes, date ceased: ☐ No

Do you drink alcohol: ☐ Yes ☐ No If 'yes', how many standard drinks per week:

Do you take recreational drugs: ☐ Yes ☐ No If 'yes', name & frequency:

Consumption of more than 2 x cups of coffee/tea/energy drink daily: ☐ Yes ☐ No If 'yes', how many daily:

Exercise times per week: Average mins per session: Diet: Normal ☐ Special ☐ Details:

TREATMENT TYPE PLANNED AT CARE FERTILITY

☐ Artificial insemination (IUI) ☐ Egg freezing ☐ Egg Donor- for:

☐ Invitro fertilisation (IVF) ☐ Frozen embryo transfer (FET) ☐ Donor cycle:

I give permission to receive: Emails ☐ Yes ☐ No Text messages ☐ Yes ☐ No

I declare that the above information is correct:

Signature: **Date:**