CARE FERTILITY

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

FERTILITY HISTORY

CURRENT relationship: Number of children Number of pregnancies

PREVIOUS relationship/s: Number of children Number of pregnancies

Have you had a vasectomy: ☐ Yes - in year: ☐ No

Have you had a vasectomy reversal: ☐ Yes - in year ☐ No

Have you had testicular or genital surgery: ☐ Yes ☐ No If 'yes' please record:

Have you had a history of undescended testes: ☐ Yes ☐ No Have you taken steroids: ☐ Yes ☐ No

Have you had any sexually transmitted infections: ☐ Yes ☐ No If 'yes' please record:

Have you had semen analysis performed previously: ☐ Yes ☐ No If 'yes' were there any abnormalities: ☐ Yes ☐ No

Do you have any frozen sperm: ☐ Yes ☐ No If 'yes' which clinic is it stored at:

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MEDICAL HISTORY

Do you have: ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ High blood pressure, Recording: *(if applicable)*

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:

Please record any prescription medication you are taking:

Please record any supplements or herbal remedies you are taking:

Fertility supplements ☐ Yes ☐ No If 'yes' please record type & dose:

Vitamin E ☐ Yes ☐ No If 'yes', what dose: Vitamin C ☐ Yes ☐ No If 'yes', what dose:

Folic acid ☐ Yes ☐ No If 'yes', what dose: Other:

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:

RELEVANT INFORMATION

Have you been given advice on the association of male infertility and increased lifelong risk of testicular cancer

☐ Yes ☐ No

Have you been advised to ejaculate 2-3 times a week during the 3 months prior to treatment cycle.

☐ Yes ☐ No

Have you been advised to ensure 2 days abstinence before a seminal fluid collection.

☐ Yes ☐ No

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

I declare that the above information is correct:

Signature: **Date:**