- In order to have some background information on your case, please complete this questionnaire and bring it along for your initial consultation.
- Please note that some questions can only be filled in during your consultation or by the doctor, answer only '**SECTION A and B**' of this questionnaire.
- If you have results from any previous tests, please bring them with you.
- WE UNDERSTAND THAT INFORMATION CAN BE CONFIDENTIAL SO PLEASE LEAVE BLANK ANY AREAS THAT YOU ARE NOT HAPPY WITH OR DO NOT UNDERSTAND.
- Please, note that the information you have provided would be used for your record with the clinic and The Bridge Clinic will not be held accountable for any misinformation.
- If you are filling the electronic copy of this form, please right-click on the open-ended questions and click on "checked" to answer the questions appropriately.

Hospital No.: ______ Consultation Date: ___ / ___ / ___

Date of enquiry: ___ / ___ / ___

## SECTION A

Which name would you like us to call you?

Woman's FIRST NAME: ______ MIDDLE NAME: ______

SURNAME: ______

D.O.B. ___ / ___ / ___ AGE: ______

Woman's SURNAME AT BIRTH: ______

Man's FIRST NAME: ______ MIDDLE NAME: ______

SURNAME: ______

D.O.B. ___ / ___ / ___ AGE: ______

Address: ______

______

| Telephone No: | Woman | Man |
|---|---|---|
| Home | | |
| Office | | |
| Mobile | | |
| E-mail: | | |
| Occupation: | | |
| Language: | | |
| City/country of birth: | / | / |
| Nationality: | | |
| Religion: | | |


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| Next of kin: | | |
|---|---|---|
| Relationship : | | |
| Telephone No: | | |

Have you ever had treatment at The Bridge Clinic? YES ☐ NO ☐

If the answer to the above is **yes** What year? ____

How did you get to know about The Bridge Clinic? (PLEASE, TICK APPROPRIATELY)

- Media ☐ Please, indicate type ____
- Website ☐
- Friends/acquaintance ☐
- Doctor ☐
- Nurse ☐
- Old clients ☐

If through a doctor, did the doctor refer you? YES ☐ NO ☐

If yes, please provide the details below:

Doctor's Name: ____

Hospital: ____

Address: ____

____

Tel No(s): ____

E-mail: ____

Will you like us to communicate your treatment with your doctor? YES ☐ NO ☐

When did you get married or how long have you been together with your partner? ____

When did you first attempt to conceive a baby? ____


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## SECTION B

Have you ever been pregnant? YES ☐ NO ☐

If yes, please outline the details of the pregnancies chronologically in the table below

| Year | OUTCOME (Normal delivery, Abortion or Miscarriage) | SEX | Any complications (infection, bleeding e.t.c) | Did you conceive without help? | Child alive and well? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

How many of the pregnancies were with your current partner? ☐

Does your current partner have other children? YES ☐ NO ☐

How many of the pregnancies were with your previous partner? ☐

Does your previous partner have other children? YES ☐ NO ☐

Have you had previous IVF treatment cycles? YES ☐ NO ☐

If YES, where? ☐

How many eggs were collected? ☐

How many embryos were transferred? ☐

What was the outcome? ☐

Have you had previous IUI treatment? YES ☐ NO ☐

If YES, where? ☐

How many times? ☐

What was the outcome? ☐

**History**

- Do you have periods? YES ☐ NO ☐
- What age were you when you started having periods? ☐
- When was your last Menstrual Period ☐
- Do you have a period every month? YES ☐ NO ☐
- How many days do you bleed for? ☐
- What is the duration between periods? ☐
i.e.1st day of one period to 1st day of the next period)
- If you don't have periods, when was the last time you had a period? ☐
- Have you ever had fibroids removed? YES ☐ NO ☐
- How many times? ☐
- When was your last pap smear? ☐
- Was it Normal YES ☐ NO ☐

**Have you ever used any of the following contraceptive methods? State the duration of use**

| | | |
|---|---|---|
| The Combined Pill: | YES ☐ | NO ☐ |
| The Mini Pill | YES ☐ | NO ☐ |
| Injections/Implants: | YES ☐ | NO ☐ |
| Condoms | YES ☐ | NO ☐ |
| Spermicides | YES ☐ | NO ☐ |
| Intrauterine Device: (IUD) | YES ☐ | NO ☐ |
| Diaphragm/ Cervical Cap | YES ☐ | NO ☐ |
| Natural Methods | YES ☐ | NO ☐ |


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**Are you aware of any allergies?** YES ☐ NO ☐

Drugs: ☐

Others: ☐

## Family History

Is there any history of the following conditions in your family?

- Genetically inherited conditions YES ☐ NO ☐

- Details: ☐

## Past Medical History

- Do you have any history of the following medical conditions?
  - Asthma YES ☐ NO ☐
  - Diabetes YES ☐ NO ☐
  - Hypertension YES ☐ NO ☐
  - Sexually acquired infections YES ☐ NO ☐

Which one:

Others:

## Man's History

Have you had any operations? YES ☐ NO ☐

Chronology of previous operations

| Year | **Operation** | **Where** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Have you had a sperm test done? YES ☐ NO ☐

Was it normal? YES ☐ NO ☐

Did you have sperm cells? YES ☐ NO ☐

Can you produce a semen sample by masturbation? YES ☐ NO ☐

If you are unable to produce by masturbation, then you will require semen freezing as back up.

Past Surgical History

Chronology of previous operations (Woman)

| Year | Operation | Where |
|---|---|---|
| | | |
| | | |
| | | |

**Smoking/Alcohol**

| | Woman | Man |
|---|---|---|
| How many cigarettes per week? | | |
| How many units of alcohol per week? | | |

Do you have any other conditions that we should be aware of?

**What regular medications do you take?**

| | Woman | Man |
|---|---|---|
| Analgesics | | |
| General/other | | |

**What previous investigations have you had?**

HORMONAL TEST YES ☐ NO ☐ DATE:

Result:


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SEMEN TEST YES ☐ NO ☐ DATE: ☐

Result: ☐

HSG (X-ray of the womb) YES ☐ NO ☐ DATE: ☐

Result: ☐

LAPAROSCOPY YES ☐ NO ☐ DATE: ☐
(Operation where a telescope is inserted through the belly button to view the pelvis) RESULT: ☐

HYSTEROSCOPY YES ☐ NO ☐ DATE: ☐

Result: ☐

**What were you told is the REASON for your delay in experiencing conception?**

Sperm problem ☐
Ovulation ☐
Blocked tubes ☐
Fibroids ☐
Unexplained ☐
***please tick appropriately***
Others; Specify: ☐


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THIS SECTION IS TO BE COMPLETED BY THE DOCTOR AT 2ND CONSULTATION

**General examination**

| **Examinations** | **Findings** |
|---|---|
| Abdominal | |
| Breasts | |
| Height | |
| Weight | |
| BMI $W/H^2$ | |
| Cardiovascular | |
| Respiratory | |
| Blood pressure | |
| Chest | |

**Gynaecological examination/Ultrasound scan**

| **Examination** | **Result** |
|---|---|
| Vulva | |
| Vagina | |
| Cervix | |
| Uterus | |
| Endometrium | |
| Ovaries | |

Fibroids: Yes ☐ No ☐

- Number: ☐
- Size of largest: ☐

Endometrial:
Distortion Yes ☐ No ☐


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**Investigation request:** ***(Please indicate on case notes on DYNAMED)***

| | | |
|---|---|---|
| **Is this client to be scheduled?** | YES ☐ | NO ☐ |
| **Does the gentleman require semen freezing?** | YES ☐ | NO ☐ |
| **Are they to be put on OD waiting list?** | YES ☐ | NO ☐ |
| **Do they require surrogacy?** | YES ☐ | NO ☐ |
| **Do they require family balancing?** | YES ☐ | NO ☐ |

| | |
|---|---|
| **Working diagnosis before treatment** | |
| **Treatment plan** | |
| **Consent Form** | |
| **Name of Doctor** | |
| **Date of consultation** | / / |


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