



McGill University Health Centre

McGill Reproductive Centre



Please complete this form and bring to your appointment. After reading the information package prepare a list of questions you might wish to ask the doctor. All data provided will be treated as strictly confidential.

Please circle the correct answer. (Example: Are your periods painful? Yes/ No)

	Female	Male
1. Surname	_____	_____
2. First name	_____	_____
3. Date of birth	_____ Age _____	_____ Age _____
4. Marital status	_____	_____
5. Maiden/Previous Names	_____	_____
6. Occupation	_____	_____
7. Telephone no. (Home)	_____	_____
8. Telephone no. (Work)	_____	_____
	Can we call you at work? Y/N	Can we call you at work? Y/N
9. Medicare number:	_____	_____
	Expiry date: _____	Expiry date: _____
10.	Address in Canada:	Foreign Address:
Street:	_____	_____
City:	_____	_____ Country:
Postal code:	_____	_____
E-mail address:	_____	
Credit Card Number (out of town patient only):	_____ <i>MC/VISA/AMEX</i>	
Expiry Date:	_____	
11. Referring doctor:	General Practitioner/Gynecologist/Other specialist	
Name:	_____	Telephone no. _____
Address:	_____	

Female Partner

Height: _____

Weight: _____

Menstrual History:

12. Age when periods first started _____ years

13. How often do your periods come ? _____ / _____ days.

average / range

(Example - average 28 days / range 26-35)

14. How many days does your period last ? _____ days

15. Are your periods painful ? **Yes/No**
If yes, state which day of the menstrual cycle (first day of your cycle is the first day you bleed). _____

16. Have your periods ever stopped (excluding pregnancy) **Yes/No**

17. Previous Pregnancies:

	Present Partner	Previous Partner(s)
Year and outcome	_____	_____
	_____	_____
	_____	_____

18. Contraception:

		Dates and total duration of use	
Pill	Y/N	_____	Brand _____
Intrauterine device	Y/N	_____	Type _____
Other : _____		_____	Sterilization Y/N

Gynecological History

19. Have you had an history of:
Vaginal discharge requiring treatment / Sexually transmitted disease / Pelvic inflammatory disease /
Surgery on your tube / Removal of your appendix / Laparoscopy / Hysteroscopy / Surgery on your cervix/ Laser
/ Diathermy (LEEP)/ Repair
Any other abdominal operations ? If yes, please give details _____

20. Date of last PAP test _____

21. Was it normal ? **Yes /No**

22. Have you ever had an abnormal result **Yes /No**

If yes give dates: _____

Sexual History

23. On average, how often do you have sexual intercourse? _____ **per week/month**

General Health:

24. Is your weight stable / increasing / decreasing ?

25. Have you ever had varicella (chicken pox)? **Yes/No**

If not, have you been immunized against varicella? **Yes/No**

26. Have you had any serious illnesses in the past ? **Yes/No**

If so, please give details:

27. Have you ever had a discharge from your nipples ? **Yes/No**

28. Do you have a problem with body hair? **Yes/No**

(for example facial hair)

29. Do you have any conditions which run in your family ? **Yes/No**

(for example Sickle cell / Thalassemia status - negative /trait)

If yes, please give details:

30. Are you on any long term medications ? If yes, please give names and dosages: **Yes/No**

31. Do you have any allergies ? If yes, please give details: **Yes/No**

32. How many cigarettes do you smoke ? (enter 0 if non-smoker) _____ **per week**

33. How many glasses of alcohol do you drink ? _____ **per week**

34. Do you have any serious illnesses in your family ? **Yes/No**

If yes, please give details:

Infertility History:

35. As a couple, how many years have you been having sexual intercourse without using contraception?__ **years**

36 Previous infertility investigations

Yes/No

37. Please complete this table if you ever had ovulation induction with or without intrauterine insemination:

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5
Year					
Number of cycles					
Centre					
Clomid (Y/N)					
Gonadotropins (Y/N)					
Intrauterine insemination (Y/N)					
Husband/Donor					
Abandoned (Y/N)					
Pregnancy (Y/N)					

38. Have you ever had In-Vitro Fertilization (*test-tube treatment*),GIFT (*Gamete Intra-Fallopian tube transfer*) or ZIFT (*Zygote Intra-Fallopian tube Transfer*) ?

Yes/No

If yes, please complete this table

	Cycle 1	Cycle 2	Cycle 3	Cycle 4	Cycle 5
Year					
Doctor					
Centre					
No. amp. gonadotropins					
Eggs obtained					
Eggs fertilized					
Embryos transferred					
ICSI (Y/N)					
Husband/Donor					
Abandoned (y/n)					
Pregnancy (y/n)					

Male Partner

39. Have you ever had

Undescended testis / Surgery to bring down testicle / Surgery for hernia / Surgery for prostate enlargement / Surgery for torsion of testicle / Hypospadias (*urethral opening on the underside of the penis*) / Accident involving your genitalia / Discharge needing treatment/ Diagnosed sexually transmitted disease / Inflammation of testicle or epididymis / Mumps (as an adult / Cystoscopy / Scrotal *surgery (surgery to your testicule)* / Vasectomy / Previous radiotherapy / Previous chemotherapy

If you had any of above please give details:

40. Do you have any children from previous relations ? **Yes / No**

If yes - how many ? _____

41. Do you have any problems with sexual intercourse? **Yes / No**

42. Are you able to produce a semen sample by masturbation ? / **Yes /**

No

43. Previous infertility investigations and treatment? **Yes / No**

44. Have you had any serious illnesses in the past? **Yes/No**

If yes, please give details:

45. Are you on any long term medications ? If yes, please give names and dosages: **Yes/No**

46. Do you have any conditions which run in your family? **Yes/No**

(for example Sickle Cell / Thalassemia Status - negative / trait?)

If yes, please give details:

47. Do you have any allergies? If yes, please give details: **Yes/No**

48. How many cigarettes do you smoke? (enter 0 if non-smoker) _____ **Per Week**

49. How many glasses of alcohol do you drink? _____ **Per Week**

Female partner

Psychosocial Aspects
(to be completed separated by each spouse/individual)

50. Have you ever been diagnosed with a psychological/emotional problem? If yes, please describe.

51. Have you ever received any type of psychotherapy or counseling? If yes,
When? _____, Duration? _____ Type of Intervention?

52. Would you describe yourself as an anxious person? Yes/No _____

53. Would you describe yourself as a depressed person? Yes/No _____

54. Apart from infertility, are you under any unusual stresses (personal, work, relational)? Yes/No _____.
If yes, please describe _____

55. Do you feel you have a strong support network to help you through the process of fertility treatments? Please describe. _____

56. Has infertility had a negative impact on:

Interactions with friends/family? Yes/No _____

Intimate/sexual relations? Yes/No _____

Self-esteem? Yes/No _____

Body-image? Yes/No _____

57. Are you concerned that you may not cope well with any aspects of the treatment process? Yes/No _____.
If yes, please explain _____

58. Do you have any religious considerations that may affect your fertility treatments?

Yes/No _____. If yes, please
describe _____

Male partner

Psychosocial Aspects
(to be completed separated by each spouse/individual)

50. Have you ever been diagnosed with a psychological/emotional problem? If yes, please describe.

51. Have you ever received any type of psychotherapy or counseling? If yes,
When? _____, Duration? _____ Type of Intervention?

52. Would you describe yourself as an anxious person? Yes/No _____

53. Would you describe yourself as a depressed person? Yes/No _____

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58. Do you have any religious considerations that may affect your fertility treatments?

Yes/No _____. If yes, please

describe _____

Review visit:

Date:

Review visit:

Date:

Review visit:

Date:

Review visit:

Date:

Review visit:

Date:

Review visit:

Date:
