



ENTRY FORM WOMAN

INVUL-V-E

PERSONAL DETAILS

Date of entry ▶ / /

Name ▶

Partner's name ▶

Length of your relationship ▶

Address ▶

Date of birth ▶ Partner's date of birth ▶

Telephone number (daytime) ▶ Telephone number (evening) ▶

Mobile ▶

e-mail ▶

Current employment ▶

DETAILS OF DOCTOR

No referring doctor

Family doctor

Name ▶

Adress ▶

Tel. ▶

Fax ▶

Practice ▶

Gynaecologist

Name ▶

Adress ▶

Tel. ▶

Fax ▶

Practice ▶

MEDICAL HISTORY

Weight ▶kg Height ▶cm

Blood type ▶

Have you lost more than 10 kg in the last year?

No Yes

Are you on a special diet or do you have special dietary habits?

No

Yes (if yes, please specify) ▶

.....

Do you exercise regularly?

No

Yes (if yes, please specify) ▶

How many hours a week? ▶

Have you ever had a pelvic ultrasound (for a treatment or diagnosis)?

No Yes

Have you taken any (prescription) medication in the past year?

No

Yes, (please specify which medication and why you were taking it) ▶

.....

Have you taken any over-the-counter medication in the past year?

No

Yes, (please specify which medication and why you were taking it) ▶

.....



ENTRY FORM WOMAN

Do you suffer, or have you ever suffered, from:

- | | |
|---|--|
| <input type="radio"/> Allergies | <input type="radio"/> High blood pressure |
| <input type="radio"/> Anaemia | <input type="radio"/> Kidney infection |
| <input type="radio"/> Appendicitis | <input type="radio"/> Liver problems |
| <input type="radio"/> Arthritis | <input type="radio"/> Loss of balance |
| <input type="radio"/> Blood transfusion | <input type="radio"/> Measles |
| <input type="radio"/> Chlamydia infection | <input type="radio"/> Neurological problems |
| <input type="radio"/> Chronic bronchitis | <input type="radio"/> Ovarian cysts |
| <input type="radio"/> Chronic headaches | <input type="radio"/> Painful or sensitive chest |
| <input type="radio"/> Colitis | <input type="radio"/> Parasitic infection |
| <input type="radio"/> Colour blindness | <input type="radio"/> Pelvic infection |
| <input type="radio"/> Convulsions | <input type="radio"/> Pneumonia |
| <input type="radio"/> Diabetes | <input type="radio"/> Poor sense of smell |
| <input type="radio"/> Dizziness | <input type="radio"/> Rheumatism |
| <input type="radio"/> Endometriosis | <input type="radio"/> Scarlet fever |
| <input type="radio"/> Epilepsy | <input type="radio"/> Syphilis |
| <input type="radio"/> Excessive hair growth | <input type="radio"/> Thyroid problem |
| <input type="radio"/> Gall bladder problems | <input type="radio"/> Tuberculosis |
| <input type="radio"/> German measles | <input type="radio"/> Ulcers |
| <input type="radio"/> Gonorrhoea | <input type="radio"/> Urethritis |
| <input type="radio"/> Heart condition | <input type="radio"/> Vaginitis |
| <input type="radio"/> Hepatitis | <input type="radio"/> Visual disturbances |
| <input type="radio"/> Herpes | |

Have you ever been treated for cancer?

- No
- Yes (please specify what and when)
- ▶
-

Do you use, or have you ever used, the following?

- Alcohol (if yes, how many glasses a day?)
- ▶
- Tobacco (if yes, how many cigarettes or cigars a day?)
- ▶
- Drugs (if yes, what and to what extent?)
- ▶

YOUR MENSTRUAL AND PREGNANCY HISTORY

Since when have you been trying to get pregnant (month and year)?

▶

At what age did you have your first period?

▶

When was your last period? (date)

▶

Are your periods regular?

- No Yes

What is the usual number of days between two periods?

▶

What is the usual duration of your period?

▶

Do you have cramps after or during your period?

- No
- Yes, (if yes, are the cramps):
- Mild Moderate Severe

Do you take pain medication for cramps?

- No
- Yes (if yes, please specify which medication)
- ▶

Do you bleed or spot between periods?

- No Yes

Were there any complications during or after your pregnancy (or pregnancies)

- No
- Yes (if yes, please specify)
- ▶
-
-

Did your mother have any difficulty with conception or pregnancy?

- No
- Yes (if yes, please specify)
- ▶
-

In your family:

- have any children been born with abnormalities?
- are there any known congenital disorders?
- do the men or women have problems with cancer?
- No
- Yes (if yes, what and who?)
- ▶
-

Is there any history of hormonal or congenital disorders in your family?

- No
- Yes (if yes, who?)
- ▶



How many pregnancies (including miscarriages or abortions) have you had?

	When (year)	Ending in miscarriage	Ending in abortion	Ending in ectopic pregnancy	Was infertility therapy required to conceive?	How long did it take to conceive?	Was your child born alive?	Is your current partner the father?
1st pregnancy								
2st pregnancy								
3st pregnancy								
4st pregnancy								
5st pregnancy								

CONTRACEPTIVE HISTORY

Which of the following forms of contraception do you use now or have you used in the past:

- none
- the pill (if yes, please specify) ▶
- coil
- diaphragm
- condom
- abstention
- other (specify) ▶

If you ever took the pill, were your periods regular after you stopped taking it?

- No
- Yes

How many times a week do you and your partner have sexual intercourse?

▶

How many times a week do you have sexual intercourse around the time of ovulation? (approximately halfway through the menstrual cycle)

▶

Is intercourse painful or difficult for you?

- No
- Yes

Do you use lubricants?

- No
- Yes

Which of the following tests have you had and what was the result (if known)?

Test	Year	Result
<input type="radio"/> Temperature chart	
<input type="radio"/> Post-coital test	
<input type="radio"/> Hormonal blood test	
<input type="radio"/> Ultrasound	
<input type="radio"/> Endometrial biopsy	
<input type="radio"/> Hysterosalpingogram (HSG)	
<input type="radio"/> Antibody testing	
<input type="radio"/> Laparoscopy, Hysteroscopy	
<input type="radio"/> Mycoplasma / Chlamydia cultures	
<input type="radio"/> Thyroid tests		
<input type="radio"/> Other (please specify)	
	
	
	

Have you ever had surgery for tubal reversal?

- No
- Yes (if yes, when?) ▶

Have you ever had any other pelvic or abdominal surgery? (e.g. appendectomy, ...)

- No
- Yes



ENTRY FORM WOMAN

Have you ever had any surgery on your cervix or vagina?
(e.g. conisation, ...)

- No Yes

Have you ever had an operation on your womb? (e.g. removal of a septum ...)

- No Yes

FERTILITY TREATMENT HISTORY

Have you been treated for infertility before?

- No
 Yes (if yes, when and who was your doctor?)

▶
.....

What cause of reduced fertility was diagnosed?

▶
.....

What fertility drugs have you taken?

- None
 Clomiphene citrate (Pergotime®, Clomid®)
 hMG (Menopur®, Humegon®)
 Estrogens
 Progesterone
 Cortisones
 Antibiotics
 LHRH, GnRH (HRF®)
 hCG (Pregnyl®, Choragon®)
 Bromocriptine (Parlodel®, Dostinex®)
 Danazol (Danazol®)
 FSH (Puregon®, Gonal-F®)
 Other (please specify) ▶

.....
.....

Is your partner seeing a doctor for infertility evaluation?

- No Yes

Does that doctor feel that your partner has an infertility problem?

- No
 Yes (if yes, what is the diagnosis and what treatment was suggested?) ▶

.....
.....

Have you ever had artificial insemination or in-vitro fertilisation?

- No
 Yes (if yes, using partner or donor sperm?)

- Partner sperm
 Donor sperm

How many cycles? ▶

What was the result (pregnant or not)? ▶

.....

Have you and your partner ever tried IVF or ICSI?

- No

Yes ▶

When ▶

Where ▶

Result ▶

.....

which other possible treatment have you and your partner undergone with regards to your fertility problem?

▶
.....
.....

