Brussels IVF

INVUL-V E

ENTRY FORM WOMAN

PERSONAL DETAILS

Date of entry ▶ .....
Name ▶ .....
Date of birth ▶ .....
Address ▶ .....
Telephone number (daytime) ▶ .....
Telephone number (evenings) ▶ .....
Mobile ▶ .....
E-mail ▶ .....
Current employment ▶ .....

IF APPLICABLE

Partner's name ▶ .....
Partner's date of birth ▶ .....
Length of your relationship ▶ .....

DETAILS OF DOCTOR

○ **No referring doctor**

Family doctor

Name ▶ .....
Address ▶ .....
.....
.....
Tel. ▶ .....
Fax ▶ .....
Practice ▶ .....

Gynaecologist

Name ▶ .....
Address ▶ .....
.....
.....
Tel. ▶ .....
Fax ▶ .....
Practice ▶ .....

Please specify your expectations at Brussels IVF?

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.....
.....

MEDICAL INFORMATION

Weight ▶ ..... Height ▶ .....
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 - Which? ▶ .....
.....
.....

Do you exercise regularly?
○ No ○ Yes - Which?
▶ .....
How many hours a week? ▶ .....

Do you use, or have you ever used, the following?
○ Alcohol - If so, how many glasses a day?
▶ .....
○ Tobacco - If so, how many cigarettes or cigars a day?
▶ .....
○ Drugs - If so, what and to what extent?
▶ .....

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Have you ever been exposed professionally to one of the following:

- ○ heat
- ○ chemical products
- ○ poisonous fumes
- ○ radiation
- ○ other (please specify) ▸ .....

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

- ○ No
- ○ Yes

Have you taken any prescription medication in the past year?

- ○ No
- ○ Yes - Which? Why?

▸ .....

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

- ○ No
- ○ Yes - Which? Why?

▸ .....

Have you ever been treated for cancer?

- ○ No
- ○ Yes - What type of cancer? When?

▸ .....

.....

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

- ○ allergies
- ○ anaemia
- ○ appendicitis
- ○ arthritis
- ○ blood transfusion
- ○ chlamydia infection
- ○ chronic bronchitis
- ○ chronic headaches
- ○ colitis
- ○ colour blindness
- ○ convulsions
- ○ cystic fibrosis
- ○ diabetes
- ○ dizziness
- ○ endometriosis
- ○ epilepsy
- ○ excessive hair growth
- ○ gall bladder problems
- ○ german measles
- ○ gonorrhoea
- ○ heart condition
- ○ hepatitis
- ○ herpes
- ○ high blood pressure
- ○ kidney infection
- ○ liver problems
- ○ loss of balance
- ○ measles
- ○ neurological problems
- ○ nipple discharge
- ○ ovarian cysts
- ○ painful or sensitive chest
- ○ parasitic infection
- ○ pelvic infection
- ○ pneumonia
- ○ poor sense of smell
- ○ rheumatism
- ○ scarlet fever
- ○ sinus infection
- ○ stomach ulcer
- ○ syphilis
- ○ thyroid problem
- ○ tuberculosis
- ○ urethritis
- ○ vaginitis
- ○ visual disturbances
- ○ other (please specify) ▸ .....

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FAMILY MEDICAL HISTORY

Is there a history of fertility problems in your family?

- ○ No
- ○ Yes - Who?

▸ .....

Did your mother have any difficulty with conception or pregnancy?

- ○ No
- ○ Yes - Which difficulty?

▸ .....

.....

In your family:

- have any children been born with abnormalities?
- are there any known congenital disorders?
- do members of your family have problems with cancer?

- ○ No
- ○ Yes - What? Which family member?

▸ .....

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

- ○ No
- ○ Yes - Which family member?

▸ .....

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INFORMATION ABOUT YOUR MENSTRAL CYCLE, THE DESIRE TO HAVE CHILDREN AND POSSIBLE PREGNACIES

Menstruation

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 - The cramps are: ☐ mild ☐ moderate ☐ severe

Do you take pain medication for cramps?

◯ No ◯ Yes - Which medication?

▶ .....

Do you bleed or spot between periods?

◯ No ◯ Yes

Contraconception and fertility

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

◯ none
◯ the pill - which one? ▶ .....
◯ coil
◯ diaphragm
◯ condom
◯ abstention
◯ other (please specify) ▶ .....

If you ever took the pill, were your periods regular after you stopped taking it? ◯ No ◯ Yes

The desire to have children

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

▶ .....

How many times a week do you 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

Test/procedures

Which of the following tests have you had?
What was the result?

Test	Year	Result
◯ temperature chart	.....	.....
◯ post-coital test	.....	.....
◯ hormonal blood test	.....	.....
◯ ultrasound	.....	.....
◯ endometrial biopsy	.....	.....
◯ hysterosalpingogram (HSG)	.....	.....
◯ antibody testing	.....	.....
◯ laparoscopy - hysteroscopy	.....	.....
◯ mycoplasma / chlamydia	.....	.....
◯ thyroid tests	.....	.....
◯ other (please specify)	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Have you ever had surgery for tubal reversal?

◯ No
◯ Yes - When?

▶ .....

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

◯ No ◯ Yes

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

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Pregnancies

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

	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy	5th pregnancy
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?					

Were there any complications during or after your pregnancy/pregnancies? ○ No ○ Yes - Which? ▶ .....

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INFORMATION ABOUT POSSIBLE EARLIER FERTILITY TREATMENT

Have you been treated for infertility before?

○ No ○ Yes - When? Who was your doctor?

▶ .....

.....

What cause of reduced fertility was diagnosed?

▶ .....

What fertility drugs have you taken?

- ○ none
- ○ clomiphene citrate (Pergotime®, Clomid®)
- ○ estrogens
- ○ cortisones
- ○ LHRH, GnRH (HRF®)
- ○ bromocriptine (Parlodel®, Dostinex®)
- ○ FSH (Puregon®, Gonal-F®)
- ○ other (please specify) ▶ .....

.....

- ○ hMG (Menopur®)
- ○ progesterone
- ○ antibiotics
- ○ hCG (Pregnyl®, Choragon®)
- ○ danazol (Danazol®)

Is your partner seeing a doctor for infertility evaluation?

○ No ○ Yes

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

○ No ○ Yes - What is the diagnosis and what treatment was suggested? ▶ .....

.....

Have you ever had artificial insemination?

○ No

○ Yes - With what 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?

▶ .....

.....

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