City Fertility Centre
your partners in life

REGISTRATION FORM

PATIENT DETAILS (Female)		**PARTNER'S DETAILS** (if applicable)	
Surname		**Surname**	
First Name		**First Name**	
Maiden Name			
Date of Birth		**Date of Birth**	
Address		**Address (or as 'Partner')**	
Postal Address		**Postal Address**	
Have you resided overseas for a period of 12 months or more within the last 10 years?	☐ Yes ☐ No	**Have you resided overseas for a period of 12 months or more within the last 10 years?**	☐ Yes ☐ No
Medicare Number		**Medicare Number**	
Expiry Date		**Expiry Date**	
Reference Number (number next to name)		**Reference Number (number next to name)**	
Telephone – Home		**Telephone – Home**	
Work		**Work**	
Mobile		**Mobile**	
Fax		**Fax**	
Email		**Email**	
Occupation		**Occupation**	
Country of Birth			
Known Allergies			
Height (cm)	**Weight (kg)**		
Referring Family Doctor (GP)	**Name**		
	Address		

City Fertility Specialist		MANDATORY
Do you require an interpreter?	☐ Yes	☐ No
If yes, for which language?		
Do you have a physical disability?	☐ Yes	☐ No
If yes, do you require Wheelchair Access?	☐ Yes	☐ No
Are you visually or hearing impaired?	☐ Yes	☐ No
If yes, do you require assistance for	☐ Hearing	☐ Seeing

How did you hear about the clinic?				
	☐ Radio	☐ Yellow Pages	☐ Brochure	☐ Friend or Relative
	☐ Magazine	☐ Cinema/Billboard	☐ White Pages	☐ Referring GP
	☐ Internet Search Engine		☐ Internet Website Searching	

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MEDICAL HISTORY

PATIENT TO COMPLETE

Name				
Date of Birth				
Have you ever smoked?	☐ Currently	☐ Previously	☐ No	
If yes, how many a day?				
Do you consume alcohol?	☐ Yes	☐ No		
If yes, how many glasses per week?				
Are your periods regular?	☐ Regular (beginning every 21-38 days)	☐ Irregular	☐ Absent	
What is the average duration of your cycle?	Days			
Are you taking any regular medication/herbal remedies?	☐ Yes	☐ No		
If yes, what are they?				
Have you previously had surgery?	☐ Yes	☐ No		
If yes, please specify				
Have you had a general anesthetic?	☐ Yes	☐ No		
Any problems with this?				
Significant medical history?	☐ Asthma	☐ Diabetes	☐ Epilepsy	☐ High Blood Pressure
Other?				

PARTNER TO COMPLETE (if applicable)

Name				
Date of Birth				
Have you ever smoked?	☐ Currently	☐ Previously	☐ No	
If yes, how many a day?				
Do you consume alcohol?	☐ Yes	☐ No		
If yes, how many glasses per week?				
Are you taking any regular medication/herbal remedies?	☐ Yes	☐ No		
If yes, what are they?				
Have you previously had surgery?	☐ Yes	☐ No		
If yes, please specify				
Have you had a general anesthetic?	☐ Yes	☐ No		
Any problems with this?				
Significant medical history?	☐ Asthma	☐ Diabetes	☐ Epilepsy	☐ High Blood Pressure
Other?				

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FERTILITY HISTORY

FEMALE

Has an explanation for your infertility been identified?	☐ Yes If yes, please record below		☐ No	
Tubal	☐ Pelvic Inflammatory Disease		☐ Previous Ectopic Pregnancy	
	☐ Sterilisation		☐ Multiple Tubal Causes	
	☐ Removal of Tube or Tubes		☐ Congenital Tubal Defect	
Endometriosis	☐ Mild	☐ Moderate	☐ Severe	☐ Not known
Polycystic Ovaries (PCO)				
Ovulation Disorder				
Other				

MALE (if applicable)

Azoospermia (no sperm)	☐ Yes	☐ No
Oligospermia (low sperm count)	☐ Yes	☐ No
Decreased Motility	☐ Yes	☐ No
Abnormal Sperm Morphology	☐ Yes	☐ No
Endocirne Disorders	☐ Yes	☐ No
Sterilisation (Vasectomy)	☐ Yes	☐ No
Unsuccessful Vasectomy Reversal	☐ Yes	☐ No
Other	☐ Yes	☐ No

PREGNANCY- FEMALE

Total Number of Pregnancies			
Number of Children in Current relationship		**Number of Children in Previous relationships**	
Number of Miscarriages & Weeks Gestation			
Number of Terminations			
Number of Ectopic Pregnancies			
Number of Still Births & Weeks Gestation			

PREGNANCY- PARTNER (if applicable)

Number of Children in Current relationship		Number of Children in Previous relationship	

PREVIOUS TREATMENTS

Have you Previously Undergone Infertility Treatment	☐ Yes	Number of Cycles ☐	WHEN		☐ No
Have you Previously Undergone Intrauterine Insemination Cycles	☐ Yes	Number of Cycles ☐	WHEN		☐ No
Have you Previously Undergone IVF Cycles	☐ Yes	Number of Cycles ☐	WHEN		☐ No
Have you previously frozen Embryos	☐ Yes	Number of Cycles ☐	WHEN		☐ No

I DECLARE THAT THE ABOVE INFORMATION IS CORRECT			
PATIENT SIGNATURE		**DATE**	
PARTNER SIGNATURE		**DATE**	