

REGISTRATION FORM

Surname	PATIENT DETAILS (Female)					PARTNER'S DETAILS (if applicable)						
First Name	Surnama	(1 611	idicj			Curnama		(11 6	іррпсавіс)			
Maiden Name Date of Birth Date of Birth Address Address Cor as "Partner") Postal Address Have you resided overseas for a period of 12 months or more within the last 10 years? Medicare Number	Surname					Surname	•					
Date of Birth Address Address (or as 'Partner') Postal Address Have you resided overseas for a period of 12 months or more within the last 10 years? Medicare Number Expiry Date Expiry Date Reference Number (number next to name) Telephone - Home Work Work Work Work Mobile Fax Fax Fax Email Occupation Country of Birth Known Allergies Height (cm) Weight (kg) Name Address Address City Fertility Specialist Do you require an interpreter? If yes, do you require Wheelchair Access? Are you visually or hearing impaired? If yes, do you require an impaired? If yes, do you require wheelchair Access? Are you visually or hearing impaired? If yes, do you require wheelchair Access? Are you visually or hearing impaired? If yes, do you require wheelchair Access? Are you visually or hearing impaired? If yes, do you require wheelchair Access? Are you visually or hearing impaired? If yes, do you require wheelchair Access? Are you visually or hearing impaired? If yes, do you require seeling impaired? If yes, do you require seeling impaired? If yes, do you require wheelchair Access? Are you visually or hearing impaired? If yes, do you require seeling if yellow pages impaired? If yes, do you require seeling if yellow pages impaired? If yes, do yo	First Name					First Nan	ne					
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Postal Address Postal Address Partner') Postal Address Postal Add	Date of Birth					Date of B	Birth					
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Are you visually or hearing impaired? If yes, do you require assistance for Hearing Seeing Radio Yellow Pages Brochure Friend or Relative Magazine Cinema/Billboard White Pages Referring GP						Yes			□ No	□ No		
If yes, do you require assistance for Hearing Seeing How did you hear about the clinic? Radio Yellow Pages Brochure Friend or Relative Cinema/Billboard White Pages Referring GP						Yes			□ No	No No		
How did you hear about the clinic? Radio Yellow Pages Brochure Friend or Relative White Pages Referring GP	Are you visually	or hearing	impaire	ed?		☐ Yes ☐ No						
hear about the clinic? Magazine Cinema/Billboard White Pages Referring GP	If yes, do you require assistance for					Hearing	Hearing Seeing			eing		
hear about the clinic? Magazine Cinema/Billboard White Pages Referring GP	How did you	Radio			Yellow Pag	es Brochure				Friend or Relative		
the clinic?	hear about	Magazine Cinema/Bi							Referring GP			
—	the clinic?		Internet Search Engine				☐ Internet Website Searching					



MEDICAL HISTORY

PATIENT TO COMPLETE

Name					
Date of Birth					
Have you ever smoked?	Currently	:ly F		ısly	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 evo	erv 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	Diabe	etes	Epilepsy	High Blood Pressure
Other?					
PARTNER TO COMPLETE (if applicable)					
Name					
Date of Birth					
Have you ever smoked?	Currently	Currently		ısly	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	Diabe	etes	Epilepsy	High Blood Pressure
Other?					



FERTILITY HISTORY

FEMALE

Has an explanation for your infertility been identified?	L Yes	Yes If yes, please record below				No			
	Pelvi	: Inflar	nmator	y Disease		Previous Ectopic Pregnancy			
Tubal	Steri	isation	ı			Multiple Tubal Causes			
	Remo	Removal of Tube or Tubes				Congenital Tubal Defect			
Endometriosis	Mild			Moderate		Severe		Not known	
Polycystic Ovaries (PCO)									
Ovulation Disorder									
Other									
MALE (if applicable)	MALE (if applicable)								
Azoospermia (no sperm)		ППу	'es			□ No			
Oligospermia (low sperm coun	t)		es es			□ No			
Decreased Motility	•		es es			No			
Abnormal Sperm Morphology						□ No			
Endocirne Disorders		Yes				No			
Sterilisation (Vasectomy)		Yes				No			
Unsuccessful Vasectomy Rever	en l	☐ Yes				No			
	Sai								
PREGNANCY- FEMALE	Other Yes No								
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 a	PREGNANCY- PARTNER (if applicable)								
Number of Children in Current relationship		Number of Children in Previous relationship							
PREVIOUS TREATMENTS									
Have you Previously Undergon Infertility Treatment	e 🗌	Yes	Numb	er of Cycles		WHEN		□ No	
Have you Previously Undergon Intrauterine Insemination Cyc	e 📗	Yes	Numb	er of Cycles		WHEN		□ No	
Have you Previously Undergon IVF Cycles		Yes	Numb	er of Cycles		WHEN		□ No	
Have you previously frozen Embryos		Yes	Numb	er of Cycles		WHEN	_	□ No	
I DECLARE THAT THE ABOV	E INFOR	MATI	ON IS	CORRECT					
PATIENT SIGNATURE						DATE			
PARTNER SIGNATURE						DATE			

Date Issued: 11.10.2012 Page 3 of 3
Approved by: National Patient Services Manager