Name		DOB (dd/mm/yyyy)	
Address			

Brief description of your problem?	

Menstrual History	
How many days is your menstrual cycle *(i.e. from start of one period to the start of next one)*?	
Date of last menstrual period?	
For how many days do you bleed?	

Cervical Smear		
Have you ever had an **abnormal** smear?	☐ Yes	☐ No
If yes, did you need treatment?	☐ Yes	☐ No
If yes, please give details:		

Previous Fertility Treatment Details		
Have you ever had fertility treatment elsewhere?	☐ Yes	☐ No
If Yes, please give brief details and bring any paperwork you may have to your consultation		

Previous Pregnancy Details

Body Mass Index			
What is your height (*in cms*)?		What is your current weight (*in kgs*)?	

Medical History	
(Include surgery,/operations, childhood problems, medical conditions e.g. asthma infections)	
Current medications	
Allergies to medications	

Family History
(Include history of serious medical conditions which may be hereditary)

Lifestyle			
Cigarettes per day		Average weekly alcohol intake (units) *(I unit = ½ pint beer, 1 small glass wine)*	
Average weekly exercise undertaken			
Do you have any significant stresses in your life? ☐ Yes ☐ No If Yes, please provide details			

Is there any other information you think we should know e.g. Religious/Ethical concerns? ☐ Yes ☐ No

If Yes, please provide details

Signed _____ Date _____