FERTILITY QUESTIONAIRE

IF YOU ARE TRYING TO FALL PREGNANT, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Title:	Dr	Mr	Mrs	Ms	Miss	Date of Birth:	
Surname:						Given Name:	

INFERTILITY

How long have you been trying for a family?	Less than 6 mths	More than 6 mths
If you have been pregnant before, was there any difficulty conceiving with previous pregnancies?	Yes	No

PREGNANCY HISTORY: Number of pregnancies including miscarriages, terminations, ectopic pregnancies and deliveries

Year	Place	Gestation (weeks)	Labor, Birth & Post Natal Details	Birth Weight	Gender	Breast/Bottle	Name

Have you or your partner had any previous investigations/treatment for infertility?				Yes	No
If **Yes**, which of the following have you had (tick below)					
*Laparoscopy +/- dye studies	*Hysterosalpingogram (HSG)	*Pelvic U/S	*Clomiphene		
*Tubal surgery	*In-vitro fertilisation (IVF)	*Semen analysis	*Intracytoplasmicsperm injection (ICS)		
			Do you take recreational drugs?	Yes	No	Past

PARTNERS HISTORY

Title:	Dr	Mr	Mrs	Ms	Miss	Date of Birth:	
Surname:						Given Name:	

Does your partner have any children from a previous relationship?	Yes	No
If **YES**, was there any difficulty with conception?	Yes	No
Does your partner smoke?	Yes	No
Does your partner take recreational drugs?		
How much alcohol does your partner drink on average per week?		

Does your partner have a history of the following?				
*Undescended testes	*Testicular infection	*Varicocele	*Vasectomy Reversal	
Does your partner have any major medical illnesses?			Yes	No
If YES, please give a brief description?				

Remember to forward your completed New Patient Information Form and your completed Questionnaire back to us
to enable Dr Preetam Ganu to review prior to your appointment
by fax **08 8299 0893** or email flindersobgyn@gmail.com