conceive
The Gynaecology & Fertility Hospital

Patient label

FEMALE EVALUATION

DATE: ……TIME……

AGE: ……..…… Profession: ……..……
Married since: ……..…… years
Staying Together since: ……..…… years

Degree of consanguinity None ☐ 1st ☐ 2nd ☐

1st Marriage: ○ Yes ○ No
If no, any conception from previous marriage ……
Trying for conception since ……

Chief Complaint :

☐Primary infertility ☐Secondary infertility Duration…….. years

Others……

DETAILS OF PREVIOUS PREGNANCIES INCLUDING MISCARIAGES:

	YEAR	SPONTANEOUS OR TREATMENT	OUTCOME (SEX, BIRTH WT.)	MODE OF DELIVERY
1st				
2nd				
3rd				
4th				

MENSTRUAL CYCLES:

Cycle length ……..……
Duration ……..……
Last period ……..……

Weight ……
Length ……
BMI ……
BP ……..

Pap's smear taken: ☐ No ☐ Yes ……..
Rubella Vaccination: ☐ No ☐ Yes……...

Exercise: ☐ No ☐ Yes ……..
Allergies: ☐ No ☐ Yes ……..
Smoking: ☐ No ☐ Yes ……
Alcohol: ☐ No ☐ Yes ……
Weight changes in the last few years: ……..……

FAMILY HISTORY OF:

Diabetes ……..……
Tuberculosis ……..……..
Early Menopause ……..……

Patient label

DETAILS OF PREVIOUS TREATMENT: YEAR/PLACE/NO.

Ovulation Induction with Clomid:

……

Artificial Insemination:

……

IVF/ICSI:

……

PROTOCOL FOR IVF/ICSI DONE:

……

……

……

ANY PREVIOUS SURGERIES:

……

……

TUBAL PATENCY TEST:

……

PREVIOUS MEDICAL ILLNESSES:

……

……

……

Current Medication:

……

Examination:

General ……..

External Genitalia

Vulva/Vagina …….

Cervix …….

Ultrasound Examination: ☐ TVUS ☐ TAUS

Uterus: ☐ AV ☐ RV

……

Endometrium:

……

Ovary Right ……

Ovary Left ……

Plan of Management:

……

……

Dr. Signature

Dr. Stamp

conceive
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Patient label

MALE EVALUATION:

DATE: ……TIME…….

Age …….. years Occupation ……..……..

No. of previous marriages and duration……..

No. of children ……. Age of the last child……..……..

Past Medical History:

Hypertension : YES / NO Mumps: YES / NO Heart Disease: YES / NO

Congenital disorder: YES / NO Diabetes Mellitus: YES / NO Cystic fibrosis: YES / NO

Past surgery:

Vasectomy YES / NO Varicocele Treatment YES / NO Hydrocelectomy YES / NO Inguinal hernia YES / NO Surgery for Testicular Maldescent YES / NO

Others…….

Life style factors:

Smoking : Alcohol : Exercise:

Anabolic steroids: Allergy: Others :

Sexual and ejaculatory function:

……

Previous semen assessment test result:

……..

……

CLINICAL EXAMINATION:

General: ……..

Genitalia: Penis: Testes:

Epididymes: Vas deferentia: Varicocele;

……

Current Medication:

……

Plan of Management:

……

Dr. Signature Dr. Stamp

FEMALE PARTNER	MALE PARTNER
Surname/Family Name _____	Surname/Family Name _____
First Name _____	First Name _____
Date of Birth _____/__/____	Date of Birth _____/__/___
Nationality _____	Nationality _____
Religion _____	Religion _____
Languages Spoken _____	Languages Spoken _____

We hereby confirm that we have no objection for 'Conceive Hospital' to inform the Ministry of Health or other regulatory bodies about any notifiable infectious diseases.

_____ _____

Patient's Signature Husband's Signature

CORRESPONDENCE ADDRESS

P.O. Box_____

Emirate_____ Tel.No._____
(Residence)

Email _____ Wife Mobile No._____

Husband Mobile No._____

REFERRAL REFERENCE

FAMILY DOCTOR / SPECIALIST

Dr. _____

Address:

_____