Pre-IVF Patient Questionnaire

PATIENT DETAILS

Name: _____ Age: ____ Nationality: _____

Spouse Name: _____ Age: ____ Nationality: _____

Mobile No: _____ Email _____

Married for: _____ years

Language:

FERTILITY HISTORY

Trying to conceive for: ☐ <1 year ☐ 1–2 years ☐ >2 years

Previous pregnancy: ☐ No ☐ Yes →No. of Pregnancies_____

☐ Baby Born ☐ Miscarriage ☐ Ectopic Pregnancy

Previous fertility treatment: ☐ No ☐ Medicines ☐ IUI ☐ IVF

MEDICAL HISTORY (Female)

Any medical illness? ☐ No ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid disease ☐ Asthma ☐ Heart disease ☐ Blood disorders ☐ Other _____

☐ Genetic disorders (self/family): _____

☐ No known medical problems

Previous surgery? ☐ No ☐ Yes _____
Any drug or food allergies? ☐ No ☐ Yes → Specify: _____

Are you taking any medicines or vitamins now?
☐ No ☐ Yes → _____

LIFESTYLE

Smoking / Vaping: ☐ No ☐ Yes *Alcohol*: ☐ No ☐ Yes *Regular Exercise :* ☐ No ☐ Yes

Menstrual & Gynecological History

Periods regular? ☐ Yes ☐ No ☐ Not sure

Average cycle length: _____ days

Painful periods: ☐ Yes ☐ No

Heavy bleeding: ☐ Yes ☐ No

Known condition: ☐ PCOS ☐ Fibroids ☐ Endometriosis ☐ Thyroid ☐ None

MEDICAL HISTORY (Male)

Any medical illness? ☐ No ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid disease ☐ Asthma ☐ Heart disease ☐ Blood disorders ☐ Other _____

☐ Genetic disorders (self/family): _____

☐ No known medical problems

Previous surgery? ☐ No ☐ Yes _____
Any drug or food allergies? ☐ No ☐ Yes → Specify: _____

Are you taking any medicines or vitamins now?
☐ No ☐ Yes → _____

LIFESTYLE

Smoking / Vaping: ☐ No ☐ Yes *Alcohol*: ☐ No ☐ Yes *Regular Exercise :* ☐ No ☐ Yes

Use of Steroids: ☐ No ☐ Yes Specify: _____

MALE PARTNER (if applicable)

Semen analysis done? ☐ Yes ☐ No ☐ Not sure

☐History of surgery ☐ Infection (mumps, STI) ☐Varicocele ☐ Erectile or ejaculation problems

PATIENT UNDERSTANDING

I understand IVF success is not guaranteed and treatment may involve medicines and procedures.

DECLARATION

I confirm that the above information is true and complete to the best of my knowledge.

Patient Name: _____ Date: