Dr.Myran
Ponnam-Palam
FERTILITY SPECIALIST

MBBS BSc(Med) Hons DRACOG FRANZCOG MM
Reproductive Endrocrinology, Infertility, Gynaecology, Laparoscopic Surgery, Microsurgery

Confidential Patient Medical Questionnaire – Female

Answering the below questions accurately as possible will help us understand any issues that may be impacting your fertility. Please take your time answering all questions and return to reception.

Surname: ____________________________________ First/Middle Name:______________________________

Date of Birth:______/______/_____________

Specific questions for female :

Weight (kg):_____________ Height (cm):______________________

…………………………………(Doctor)

Please circle your response to the following questions:

Do you smoke? Yes / No How many cigarettes per day?_____________________________

Do you drink alcohol? Regularly / Rarely / Never

Have you lost or gained a lot of weight recently? Yes / No

How would you rate your workplace stress level? Extreme / Moderate / Low

Have you ever received infertility treatment? Yes / No

If yes, please specify:____

Have you ever used contraception? Yes / No

If yes, please specify: Contraceptive Pill / Condoms / intrauterine device / other___________________

……………………………………………………………………………………………………

How long is your cycle? (1st day of your period until the 1st day of your next period):___ to ___ days

How many days does your period last? ____________At what age did you first get your period?_____________

Is your period painful? Yes / No Do you feel the amount of blood loss is abnormal? Yes / No

Do you have a lot of symptoms prior to your period? Yes / No

Do you ever have spotting in between periods? Yes / No

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Please circle your response to the following questions:

Have you ever been pregnant? Yes / No If yes, when was your last pregnancy?________________

If yes, please specify how many pregnancies you have had below:

	Current Partner	Previous Partner (s)
Miscarriages		
Terminations of pregnancy		
Ectopic Pregnancies		
Live births		

If no, for how many months have you been trying to get pregnant?_______________________________

Is intercourse painful? Yes / No Do you sometimes use lubricant? Yes / No

How often do you have intercourse per month? More than 9 / 4-9 / 1-4 / Rarely

When did you have your last PAP Smear?__________Have you ever had an operation? Yes / No

If yes please circle if it was a:

Caesarean section / Laparoscopy/ Hysteroscopy / Other: _______________________________________

Please circle if you have been treated for the following – Diabetes / Thyroid disease / Tuberculosis

Have you ever been hospitalized for an illness? Yes / No If yes, please specify below:

____

Are you currently under any form of treatment? Yes / No If yes, please specify below:

____

Do you have any diseases that run in the family? Yes / No If yes, please specify below:

____

Are you currently on any medications and if yes which?______________________________________

Do you have any allergies?____

Personal Remarks: ____

____

I declare the above information to be complete and correct

Signature:____ Date: ________/______/_______