Self-Assessment Form

Please complete this form and bring it with you to your next appointment. In addition, it is important to read the document entitled "New Patient Information & Checklist" in order to prepare questions that you would want to ask the doctor at your first meeting. *(Please write in block letters)*

	Patient	Partner
1. Medicare number	_____	_____
	Expiration date _____ / _____	Expiration date _____ / _____
2. Surname	_____	_____
3. First name	_____	_____
4. Date of birth (yyyy/mm/dd)	_____ / _____ / _____	_____ / _____ / _____
	_____Age	_____Age
5. Marital status	_____	_____
6. Maiden/Previous Names	_____	_____
7. Mother's Maiden Name	_____	_____
8. Occupation	_____	_____
9. Telephone (Home)	_____	_____
10. Telephone (Cell)	_____	_____
11 Telephone (Work)	_____	_____
Can we leave a message?	☐ Yes ☐No	☐Yes ☐No
12. E-mail address	_____	_____

13. Address in Canada: _____ **City:** _____

Postal code: _____ **Province:** _____

14. Foreign Address: _____ **City:** _____

Country: _____ **Telephone:** _____

15. Referring doctor: ☐General Practitioner ☐Gynecologist ☐Other specialist _____

Name: _____

Permits: _____ Telephone: _____

Patient

1. Height: _____ **Weight:** _____

2. Do you have allergies? ☐Yes ☐No

If yes, specify: _____

Menstrual History

3. At what age did you have your first period? _____years

4. What is the frequency of your period? _____days / _____
(Example: Average 28 days/ range 26-35) average range

5. What is the duration of your period? _____days

6. Do you have painful menstruation? ☐Yes ☐No

If yes, specify the interval _____
(The first day of your cycle is the first full day of bleeding)
Example: Day 1 or Days 3-5

7. Have your periods ever stopped (excluding pregnancy) ☐Yes ☐No

8. Previous pregnancies
(Enter the first letter)
Birth **(B)**
Abortion **(A)**
Miscarriage **(M)**

	Current Partner		Previous Partner	
	Type	Year	Type	Year

9. Contraception:

			Date	Total duration of use	
Oral contraceptives (Pill):	☐Yes	☐No	_____/_____/_____	_____	Brand: _____
Intrauterine device:	☐Yes	☐No	_____/_____/_____	_____	Type: _____

Other: _____
Sterilization: ☐Yes ☐No

Gynecological history

10. Have you had a history of:

☐ Vaginal discharge requiring treatment
☐ Pelvic inflammatory disease (Salpingitis)
☐ Sexually transmitted diseases
☐ Cervical surgery (Cervical conization by laser or electrocautery)
☐ Appendectomy
☐ hysteroscopy
☐ Laparoscopy
☐ Tubal surgery

11. Have you had any other abdominal surgery? ☐Yes ☐No

If yes, specify: _____

_____

12. Date of last cytology (Pap test): _____ / _____ / _____
YYYY MM DD

13. Was it normal? ☐Yes ☐No

14. Have you ever had an abnormal result? ☐Yes ☐No

If yes, please specify the date: _____

Sexual History

15. On average, how often do you have sexual intercourse? _____ /week

General Health

16. Is your weight: ☐ Stable ☐ Increasing ☐ Decreasing

17. Have you ever had varicella (chickenpox)? ☐Yes ☐No
If not, have you ever been immunized against chickenpox? ☐Yes ☐No

18. Have you ever had any serious illnesses in the past? ☐Yes ☐No

If yes, please provide details: _____

_____

19. Have you ever had discharge from your nipples? ☐Yes ☐No

20. Do you have body hair problems? ☐Yes ☐No
(Example: facial hair)

21. Do you have any genetic conditions which run in your family? ☐Yes ☐No
(For example: sickle cell / thalassemia)

If yes, please provide details: _____

_____

22. Do you have heart and / or lung problems in your family? ☐Yes ☐No

If yes, please provide details: _____

_____

23. Do you take long-term medication? ☐Yes ☐No

If yes, please provide details: _____

_____

24. Are you smoking? ☐Yes ☐No If yes, how many cigarettes do you smoke? _____ /week

25. How much alcohol do you drink? _____ /week

26. Do you have any serious illnesses in your family? ☐Yes ☐No

If yes, please provide details: _____

_____

Infertility History

27. As a couple, how many years have you been having sexual intercourse without using contraception? _____years

28. Have you had previous infertility investigations? ☐Yes ☐No

If yes, please provide details:_____

_____

29. Please complete the following table if you have ever had an ovulation induction with or without intrauterine insemination

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5
Year					
Number of cycles					
Centre					
Clomid (Yes/ No)					
Gonadotropins (Yes/ No)					
Intrauterine insemination (Yes/ No)					
Partner / Donor					
Abandoned treatment (Yes/ no)					
Pregnancy (Yes/ No)					

30. Have you ever had In-Vitro Fertilization *(test-tube treatment)*, **GIFT** *(Gamete Intra-Fallopian tube transfer)* **or ZIFT** *(Zygote Intra-Fallopian tube Transfer)***?** ☐Yes ☐No

If yes, please complete the following table

	Cycle 1	Cycle 2	Cycle 3	Cycle 4	Cycle 5
Year					
Doctor					
Centre					
No. Amp. Gonadotropins					
Eggs obtained					
Eggs fertilized					
Embyos transferred					
ICSI (Yes/ No)					
Partner/ Donor					
Abandoned (Yes/ No)					
Pregnancy (Yes/ No)					

Partner

1. Have you ever had?

- ☐ Undescended testis
- ☐ Surgery to bring down testicle
- ☐ Surgery for hernia
- ☐ Prostate surgery
- ☐ Surgery for testicular torsion
- ☐ Hypospadias (*urethral opening in the underside of the penis*)
- ☐ Accident involving your genitalia
- ☐ Discharge requiring treatment
- ☐ Diagnosed sexually transmitted disease
- ☐ Inflammation of the testicle or epididymis
- ☐ Mumps in adulthood
- ☐ Cystoscopy
- ☐ Vasectomy
- ☐ Scrotal surgery (surgery to your testicle)
- ☐ Radiotherapy
- ☐ Chemotherapy

If you have any of these conditions or treatments, please give details:

_____

_____

2. Do you have allergies? ☐Yes ☐No

If yes, please provide details:_____

_____

3. Do you have children from a previous relationship? ☐Yes ☐No

If yes, how many? _____

4. Do you have any sexual problems? ☐Yes ☐No

5. Are you able to produce a semen sample by masturbation? ☐Yes ☐No

6. Have you had any infertility investigations or treatments? ☐Yes ☐No

If yes, please provide details:_____

_____

_____

7. Are you on any long term medications? ☐Yes ☐No

If yes, please provide details:_____

_____

8. Do you have any genetic conditions which run in your family? ☐Yes ☐No
(For example: Sickle cell / Thalassemia)

If yes, please provide details:_____

_____

_____

_____

9. Do you have heart and / or lung problems in your family? ☐Yes ☐No

If yes, please provide details:_____

_____

_____

10. Are you smoking? ☐Yes ☐No If yes, how many cigarettes do you smoke? _____ /week

11. How much alcohol do you drink? _____ /week

Patient

Psychosocial aspects

(To be completed separately by each partner)

1. Have you ever been diagnosed with a psychological or emotional problem? ☐Yes ☐No

If yes, please describe:_____

_____

2. Have you ever received any type of psychotherapy or counseling? ☐Yes ☐No

If yes, when? _____

Duration? _____

Type of Intervention? _____

3. Would you describe yourself as an anxious person? ☐Yes ☐No

4. Would you describe yourself as an emotional person? ☐Yes ☐No

5. Apart from infertility, are you under unusual stresses (personal, work, relational)? ☐Yes ☐No

If yes, please describe:_____

_____

6. Do you feel you have a strong support network to help you through the process of fertility treatments? ☐Yes ☐No

Please describe:_____

_____

7. Has infertility had a negative impact on?

- Your interactions with your friends and family? ☐Yes ☐No
- Intimate/ sexual relations? ☐Yes ☐No
- Your self-esteem ☐Yes ☐No
- Your body-image? ☐Yes ☐No

8. Are you concerned that you may not cope well with any aspects of the treatment process? ☐Yes ☐No

If yes, please explain:_____

_____

9. Do you have any religious considerations that may affect your fertility treatments? ☐Yes ☐No

If yes, please explain:_____

_____

Partner

Psychosocial aspects

(To be completed separately by each partner)

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