LYNNE CHAPMAN
REPRODUCTIVE HEALTH

# HEALTH QUESTIONNAIRE – FEMALE

***Please complete this questionnaire and provide:***

- ***A copy of your passport or ID card. Original documents will be required at your initial consultation.***
- ***Any further documentation / test results or reports.***

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| | |
| Title (Dr/Mrs/Ms Etc.): | |
| Surname: | |
| Forenames(s): | |
| Preferred Name: | |
| Previous Surname(s): | |
| Date of Birth: | |
| Age: | |
| Occupation: | |
| Passport / ID Number: | |
| Country of Issue: | |
| Relationship Status: | ☐ Married / Civil Partner (with person intending to have treatment with)<br>☐ Married / Civil Partner (with another person)<br>☐ Cohabiting<br>☐ Single<br>☐ Divorced<br>☐ Widow<br>☐ Legally Separated |
| Address: | |
| City: | |
| Postcode: | |
| Country: | |
| Place of Birth: | |

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|---|---|---|---|---|
| Country of Birth: | | | | |
| | Telephone (Home): | ☐ | | *Please include at least one contact number, preferably your mobile number.* |
| | Telephone (Work): | ☐ | | |
| | Telephone (Mobile): | ☐ | | |
| Email Address: | | | | |



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*To protect your privacy, and to comply with General Data Protection Regulations, all clinical correspondence will be encrypted via Egress. You will receive an encrypted email which will prompt you to create an Egress securely encrypted email user account. You will only need to do this once. Any subsequent emails sent will require you to merely sign into the account to access your email.* ***Please note we are not permitted to send clinical information unencrypted unless we receive your request in writing that you do not wish to receive encrypted emails.***

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| **PLEASE CHOOSE EITHER OPTION 1 OR 2 FOR EMAIL COMMS** 1. I confirm that I give my consent to receive unencrypted emails from LCRH to my personal email account as detailed above in this form. | ☐ Yes ☐ No | Please tick Y if we may contact you at your personal email address. |
| 2. I confirm that I prefer the use of **ONLY** an Egress encrypted email account for all email communication with LCRH and no emails should be sent to my personal email account under any circumstances. | ☐ Yes ☐ N/A | If you tick Y here, we will not send any emails to you at your personal email address. |

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| Do you consent to receiving reminders by text message?: | Yes ☐ No ☐ | |
| **IMPORTANT** Do you consent to share ALL your blood test and all other results with your partner here named? | Yes ☐ No ☐ | Confirm Name of Partner & your initial:<br>…… |

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| | If no, pls specify which tests **may not** be shared | |
| Ethnic Group: | | |
| Do you have a disability?: | Yes ☐ No ☐ | |
| *If yes, please give details* | | |
| **GP DETAILS** | | |
| GP Name: | | |
| GP Surgery Name: | | |
| GP Address: | | |
| GP Address City: | | |
| GP Address Postcode: | | |
| GP telephone Number: | | |



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| **EMERGENCY CONTACT** | |
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| In the event of a medical emergency, please specify emergency contact person: | ☐ Person with whom you are having treatment<br>☐ Other |
| Emergency contact name: | |
| Emergency contact telephone: | |

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| Reason for contacting LCRH: | ☐ Primary infertility (no pregnancies)<br>☐ Secondary infertility (previous pregnancies in current relationship)<br>☐ Secondary infertility (previous pregnancies in a different relationship)<br>☐ Recurrent Miscarriage<br>☐ Single person<br>☐ Same sex couple<br>☐ Fertility preservation due to medical reasons<br>☐ Fertility preservation for social reasons<br>☐ Fertility Check Up<br>☐ PGD to reduce risk of passing on genetic disorder ☐ To be an egg donor<br>☐ Egg recipient (to receive donated eggs) |
| How long have you been trying to get pregnant *(if applicable)*? | |

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| How old were you when you started periods (Menarche)? | | |
| What date was your last menstrual period? | | |
| What is your normal length of bleeding (in days)? | | |
| How long are your cycles (days)? | | Count your cycle length as the no. of days from first day of bleeding to the last day before bleeding starts again |
| Do you suffer from painful periods (Dysmenorrhoea)? | ☐ Yes ☐ No | |
| Do you suffer from heavy periods (Menorrhagia)? | ☐ Yes ☐ No | |
| Do you have bleeding after intercourse? | ☐ Yes ☐ No | |

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| Do you have bleeding between periods? | ☐ Yes ☐ No |
| Are you currently using any contraceptives? | ☐ Yes ☐ No |
| If yes, please give details | |
| When was your last smear test? | |
| What was the smear test result? | ☐ Normal ☐ Abnormal |
| Have you ever had an abnormal test? | ☐ Yes ☐ No |
| If yes, please give details | |
| Have you ever had treatment to your cervix? | ☐ Yes ☐ No |
| If yes, please give details | |
| Have you ever had any previous pelvic infections? | ☐ Yes ☐ No |
| Have you ever had any sexually transmitted diseases? Please give details. | ☐ Yes ☐ No |

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| Have you ever been diagnosed with a gynaecological condition e.g. fibroids, endometriosis, ovarian cysts? | ☐ Yes ☐ No *if yes please give details and dates below* | |
| | | |
| Have you ever had a pregnancy? *Including miscarriages, ectopic, TOPs* | ☐ Yes ☐ No | *If no, please proceed to next section* |
| | | |
| Year of pregnancy | | |
| Was it with the partner you are seeking treatment | ☐ Yes ☐ No | |

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| with? | |
| Conception method: | ☐ Natural ☐ Assisted Conception |
| Pregnancy outcome: | |
| Number of weeks gestation: | |
| Comments: | |





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| Year of pregnancy | |
| Was it with the partner you are seeking treatment with? | ☐ Yes ☐ No |
| Conception method: | ☐ Natural ☐ Assisted Conception |
| Pregnancy outcome: | |
| Number of weeks gestation: | |
| Comments: | |
| | |
| Year of pregnancy | |
| Was it with the partner you are seeking treatment with? | ☐ Yes ☐ No |
| Conception method: | ☐ Natural ☐ Assisted Conception |
| Pregnancy outcome: | |
| Number of weeks gestation: | |
| Comments: | |

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| Have you ever had a surgical procedure? | ☐ Yes ☐ No | *If yes, please give details below* |
| | | |
| Procedure type: | | |
| Procedure date: | | |
| Anaesthetic type: | | |
| Gynaecological? | | |
| Abdominal? | | |
| Comments: | | |
| | | |
| Procedure type: | | |
| Procedure date: | | |
| Anaesthetic type: | | |
| Gynaecological? | | |




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| Abdominal? | |
| Comments: | |
| Did you have any complications during these procedures? | ☐ Yes ☐ No |

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| Do you have any medical conditions?<br>*e.g. Asthma, epilepsy, diabetes, anaemia, colitis etc.* | ☐ Yes ☐ No<br>*If yes, please give details below* |
| Do you have a family history of any medical conditions?<br>*e.g. cancer, heart disease, genetic disease,* | ☐ Yes ☐ No<br>*If yes, please give details below* |
| Are you taking any medications currently?<br>*If yes, please give details* | ☐ Yes ☐ No |
| Do you have any allergies?<br>*If yes, please give details* | ☐ Yes ☐ No |
| Do you smoke?<br>*If yes, indicate how many per day* | ☐ Yes ☐ No<br>☐ Cigarettes ☐ Cigars ☐ Other |
| Do you drink alcohol?<br>*If yes, how many units per week?* | ☐ Yes ☐ No<br>Units: |
| Do you drink caffeine?<br>*If yes, how much per day?* | ☐ Yes ☐ No<br>Daily Intake: |
| Do you use recreational drugs?<br>*If yes, please give details and frequency of use* | ☐ Yes ☐ No |
| Do you use performance-enhancing drugs such as steroids/Viagra/protein supplements?<br>*If yes, please give details* | ☐ Yes ☐ No |





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| Have you travelled to a Zika or Ebola affected area in the last six months?<br>*If yes, please give details of location and dates* | ☐ Yes ☐ No |

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| *of tra vel* | | | |
| Height (metres) | | BMI | |
| Weight (kilograms) | | You can find many Body Mass Indicator (BMI) calculators online (eg: https://www.nhs.uk/live-well/healthy-weight/bmi calculator/) | |

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| Have you ever had any fertility investigations?<br>*e.g. HyCoSy, AMH, LH, TSH* | ☐ Yes ☐ No<br>*If yes, please give details, dates and results below* | |
| Have you ever had assisted conception treatment before?<br>*e.g. Ovulation Induction, IUI, IVF, ICSI* | ☐ Yes ☐ No | |
| Was the treatment with the partner you are seeking treatment with? | ☐ Yes ☐ No ☐ N/A | |
| *Please give all details of fertility treatments on the next page. Please attach any further details with this questionnaire or bring to your initial consultation so we can tailor your treatment at LCRH* | | |



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| | 1st Treatment | 2nd Treatment | 3rd Treatment | 4th Treatment | 5th Treatment | 6th Treatment |
|---|---|---|---|---|---|---|
| Year of Treatment | | | | | | |
| Treatment Type | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Centre | | | | | | |
| Sperm Source | | | | | | |
| PGD / PGD? | | | | | | |
| Number of eggs collected: | | | | | | |
| Number fertilised? | | | | | | |
| Number of embryos transferred & day of transfer: | | | | | | |
| Number of embryos frozen & day of freeze: | | | | | | |
| Pregnant? | | | | | | |
| Outcome: | | | | | | |
| Any cycle complications | | | | | | |

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| Do you have any frozen eggs, sperm or embryos in storage elsewhere? | ☐ No<br>☐ Partner Eggs<br>☐ Sperm<br>☐ Donor sperm<br>☐ Embryos | Location of samples: |

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| Do you have any further information you wish to make LCRH aware of?<br>*If yes, please details below* | ☐ Yes ☐ No | | |
| How did you hear about LCRH? | ☐ Yes Fertility Solutions | ☐ Yes Google | ☐ Yes Other (please name) |

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| Do you eat more than 5 portions of fruit and veg per day? | Ensuring at least 5 portions will nourish your body with essential vitamins, minerals and fibre |
| Do you skip meals? | Eating regular meals can support your body with the required nutrient for optimal health. |
| Do you regularly crave sugary foods? | Cravings can be controlled with a portion of wholegrain carbohydrate at every meal in addition to your fibrous veggies |
| Do you take any nutritional supplements? | It is important to give attention to this area when trying to conceive as requirements in the body change. A vitamin D and folic acid supplement are a must! |
| Do you drink more than 2 cups of coffee (4 cups of tea) per day? | Caffeine must be reduced during this time |
| Do you regularly eat confectionary foods, eat out or order takeaways? | These foods are high in added sugar, saturated fat and salt... all areas you should try to limit. |
| Do you suffer with poor digestion? | Ensure you are eating 30g of fibre per day in addition to drinking 8 glasses of fluid. |
| Do you drink alcohol at the moment? | It is always best to limit alcohol to less than 14 units per week and when you conceive, to cut it out completely |
| If you would like to understand more about your individual dietary requirements, please ask us to recommend a Nutritionist. | |

***Thank you for providing this information***