



**FEMALE (to be completed by the woman)**

Surname \_\_\_\_\_ First name \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Are you married No / Yes

Current address

Telephone No \_\_\_\_\_ Other Tel No \_\_\_\_\_

Occupation \_\_\_\_\_ Email address \_\_\_\_\_

Your GP Name \_\_\_\_\_ GP Tel No \_\_\_\_\_

GP Address

Have you attended a Hospital before in the Bristol area ? No / Yes

How long have you been together with you partner? \_\_\_\_\_

For how long have you been trying for a pregnancy? \_\_\_\_\_

When did you stop using contraception? \_\_\_\_\_

Have you ever been pregnant?..... No / Yes

If **yes**, have conceived any pregnancies in your current relationship?..... No / Yes

If **yes**, have, have conceived any pregnancies in any past relationship?... No / Yes

**If you have had any pregnancies please answer the following:**

Have you had any children?..... No / Yes

Have you had any miscarriages?..... No / Yes

Have you had any ectopic pregnancies?..... No / Yes

Have you had any termination of pregnancies?..... No / Yes

please give details of all pregnancies in the box below

	Year	Fertility treatment (yes/no)	Outcome of pregnancy	For clinic use
1.				
2.				
3.				
4.				
5.				



At what age did you start your periods? \_\_\_\_\_ When was 1<sup>st</sup> day of your last period? \_\_\_\_\_

Are you periods regular?..... No / Yes

How many days between period (ie 1<sup>st</sup> day of one to the 1<sup>st</sup> day of the next period) ..... Min Max

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How many days do you bleed for?..... \_\_\_\_\_

Do you bleed in-between periods?..... No / Yes

Do you feel your periods are heavy?..... No / Yes

Do you experience pain with periods?..... No / Yes

Do you take pain killers during a period?..... No / Yes

Have you ever had any gynaecological treatment?. No / Yes

Have you been seen in a STD or GUM Clinic?..... No / Yes

Have you ever had any genital infections?..... No / Yes

Do you have an abnormal vaginal discharge?..... No / Yes

How many time a month do you have intercourse \_\_\_\_\_

Do you experience pain during intercourse?..... No / Yes

Do you experience bleeding after intercourse?..... No / Yes

Do notice your “mid-cycle” mucus discharge?..... No / Yes

Do you specially time intercourse?..... No / Yes

Do feel you have more facial hair than normal?.... No / Yes

Do you frequently get spots on your face?..... No / Yes

Do you smoke? ..... No / Yes      Alcohol?      No / Yes

Have you ever injected drugs?. No / Yes      Other drugs?      No / Yes

Have you had any of the following illnesses?

Diabetes  chest problems  Bowel problems  Hepatitis/ HIV

Have you or your family suffered a thrombosis..... No / Yes

Any other illnesses?..... No / Yes

Have you had any treatment to your cervix?..... No / Yes

Have you had any operations?..... No / Yes

Are you taking any medication?..... No / Yes

Do you have allergies (e.g. medication)?..... No / Yes

Have you suffered from depression?..... No / Yes

Have you ever required any psychiatric treatment? No / Yes



**Do you suffer from any of the conditions listed below:**

- Irritable bowel, constipation, diarrhoea?..... No / Yes
- Cystitis, kidney, bladder problems?..... No / Yes
- Hot flushes, night sweats?..... No / Yes
- Breast discharge, breast lumps?..... No / Yes

**Have any of your relatives suffered from the any of the medical condition listed below:**

- |                       |          |                      |          |
|-----------------------|----------|----------------------|----------|
| • Diabetes            | No / Yes | • Fertility problems | No / Yes |
| • Thrombosis          | No / Yes | • Miscarriages       | No / Yes |
| • Genetic abnormality | No / Yes | • Early menopause    | No / Yes |

What is your weight?	What is your height?
Is you weight stable	No / Yes
Do you undertake regular exercise	No / Yes
Please circle what best describes your diet	Mixed/ vegetarian / other

Is there any other information that you feel is relevant?

I confirm that the information I have provided is accurate

Name

Date



**MALE (to be completed by the man)**

Surname \_\_\_\_\_ First name \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Are you married No / Yes

Current address

Telephone No \_\_\_\_\_ Other Tel No \_\_\_\_\_

Occupation \_\_\_\_\_ Email address \_\_\_\_\_

Your GP Name \_\_\_\_\_ GP Tel No \_\_\_\_\_

GP Address

Have you attended a Hospital before in the Bristol area ? No / Yes

Have you fathered any pregnancies before?..... No / Yes

Have you fathered pregnancies in this relationship? No / Yes

Do travel away from home often?..... No / Yes

Does your job expose you to any of the following:

Heat  Chemicals  Pesticides  Radiation

Have you had fertility investigations in the past?... No / Yes

Have you ever had twisting of a testicle?..... No / Yes

Have you had mumps?..... No / Yes

Have you been seen in a STD or GUM Clinic?..... No / Yes

Have you ever had any genital infections?..... No / Yes

Do you smoke? ..... No / Yes Alcohol? No / Yes

Have you ever injected drugs?. No / Yes Other drugs? No / Yes

Have you had any of the following illnesses?

Diabetes  chest problems  colitis  Hepatitis/ HIV

Any other illnesses?..... No / Yes

Have you had any operations?..... No / Yes

Are you taking any medication?..... No / Yes

Do you have any allergies?..... No / Yes

Had any mild illnesses during the past 3 months?.. No / Yes



**Do you have difficulty with intercourse or experience any of the problems listed?..... No / Yes**

- |               |          |               |          |
|---------------|----------|---------------|----------|
| • Erection    | No / Yes | • Ejaculation | No / Yes |
| • Penetration | No / Yes | • Pain        | No / Yes |

**Do any of your relatives suffer from the following conditions:**

- |                       |          |                   |          |
|-----------------------|----------|-------------------|----------|
| • Fertility problems  | No / Yes | • Cystic fibrosis | No / Yes |
| • Genetic abnormality | No / Yes | • Other condition | No / Yes |

Is there any other information that you feel is relevant?

I confirm that the information I have provided is accurate

Name

Date