DATE:.....

IVF TIME
Alpay Kalemi St. Devran
Apartment D3 Ortaköy, Nicosia /
North Cyprus

GENERAL PATIENT INFORMATION

Patient Name:	Type of Treatment:
Date of Birth:	Phone Number:
Gender: ☐ Male ☐ Female ☐ Other	Patient E-Mail:
Patient Nationality and Ethnic backround:	Patient Birth Date:
	Partner Birth Date:
Partner Nationality and Ethnic backround:	Address:
Patient Height (cm's):	How long have you and your partner been together? _____
Patient Weight (kg's):	
Patient blood type:	What is the duration of infertility? _____
Partner blood type:	

PATIENT MEDICAL HISTORY

Please answer as many questions as you can in order for us to better asses your case.

- Is there a blood relation between you and your partner? ☐ Yes ☐ No
- Do you have any allergies? If so please state them below.

_____

- Have you ever had or suffer from any of the below conditions? (Please check all that apply)

_____

- Please list your Current Medications

_____

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FEMALE INFORMATION

- Have you ever contracted any types of STD ☐ Yes ☐ No
- Do you experience any pain during sexual intercourse? ☐ Yes ☐ No
- Do you experience any pain during your menstrual cycles? ☐ Yes ☐ No
- Menstrual cycle: ☐ Regular ☐ Irregular
- Menstrual cycle length: .....
- Can you please list the types of contraceptions you have used, past and present:

- Do you have a HSG or scan pictures if so please upload:

- Have you ever been pregnant and how many times? .....
- Have you had any of the following: .....
- Please state if you have children and if any are from a different partner:

- Are there any women in your family who has had early menopause? ☐ Yes ☐ No
- Is there anyone in your family who has breast cancer? ☐ Yes ☐ No
- Is there anyone in the family who has Thrombophilia? ☐ Yes ☐ No
- Have you ever had Pelvic Tuberculosis? ☐ Yes ☐ No
- Please list the names of any Gerneral Operations and Dates of Each

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- Have you ever had any IVF proccedures before and in which country?

- Can you list how many cycles? also how many transfers?

- Can you recall how many eggs were collected and how many embryos fertilised?

- Have you had any embryos frozen and stored? ☐ Yes ☐ No
- Do you exercise: ☐ Yes ☐ No
- Alcohol Consumption: ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No
- Include other comments regarding your Medical History: .....

MALE INFORMATION

Please answer as many questions as you can.

- Please state your height: .....
- Please state your weight: .....
- At what age did you reach Puberty? .....
- Have you ever had Mumps Orchitis? ☐ Yes ☐ No
- Do you suffer from Erectile dysfunction? ☐ Yes ☐ No
- History of any STD or urinary infections? .....
- History of lung disease or chronic bronchitis? .....
- History of chemotherapy or radiotherapy? .....
- Are you exposed to any type of chemicals? .....
- Do you exercise excessively? .....
- Are you using any hormone supplements or protein products? If yes please type below
  .....

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- Are there any members of your family that suffer from male infertility?

- Do you suffer from any allergies?

- Do you have children from a different partner?

- Do you have a semen analyses report, if so please upload below:

- **"Attach File"**

FAMILY HISTORY

For both you and your partner

- Please state if there are any family members who have suffered from multiple miscarriages, stillbirths or infertility:

- Do you or anyone in your family have any genetic disorders? If so please state the diagnosis.

- Do you or anyone in your family have been diagnosed with any mental disability, disabled or down syndrome?

- Tags