

PATIENT REGISTRATION FORM

	Patient	Partner
Passport Number		
Country of issue of passport		
Title		
Family name (surname)		
Maiden / Former Name		
Given Names (First)		
Given Names (Middle)		
Would like to be known as...		
Date of birth		
Town/City of birth registration		
Country of birth		
Occupation		
Address		
Postcode		
Work Tel. No.		
Home Tel. No.		
Mobile Phone No.		
Email-address		
Preferred Mode of Contact		
Health Board		
Do you agree to GCRM corresponding with your GP?	Yes / No	Yes / No
GP name and address		
Referring consultant and address (if applicable)		
How did you hear about GCRM? (Please circle)	GCRM Website / Personal Recommendation / GP Practice / HFEA Website / Advertising / Chat Room	
I agree that the above information is correct. (*Please sign and date)	*	*

HEALTH QUESTIONNAIRE - to be completed by female partner.

MEDICAL HISTORY	YES	NO	DETAILS
Have you ever had:			
Any Allergic reactions			
High blood pressure			
Any Heart problems			
Diabetes			
Asthma			
Shortness of breath			
Thrombosis / Clots			
Epilepsy			
Hepatitis			
Jaundice			
Thyroid problems			
Anaemia			
Depression			
Stomach ulcer			
Any operation			
Any anaesthetic			
Reaction to anaesthetic			
Any other condition			
GYNAECOLOGICAL HISTORY	YES	NO	DETAILS
Have you ever had:			
Ovarian cyst			
Endometriosis			
Fibroids			
Abnormal smear			
Fertility investigations			
Any other condition			
OBSTETRIC HISTORY PREGNANCIES	YOU	Partner	DETAILS / DATES
Length of time trying			
No. of live births			
No. of miscarriages			
No. of terminations			
No. of still births			
PREVIOUS TREATMENT	YES	NO	DETAILS / DATES
IUI			
IVF			
ICSI			
Other			
SOCIAL HISTORY	YES	NO	DETAILS
Do you smoke			If yes- how many a day?
Do you drink alcohol			How much per week?
Are you on a special diet			
Are you on medication			
Recreational Drugs			
WEIGHT -			HEIGHT -