

PATIENT REGISTRATION FORM

We ask that you only provide details that you are happy for GCRM to use to contact you.

	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		
Home Address		
Home Postcode		
Work Tel. No.		
Home Tel. No.		
Mobile Phone No.		
Email-address		
Preferred Mode of Contact	Work / Home / Mobile / Email	Work / Home / Mobile / Email
Do you agree to GCRM corresponding with your GP?	Yes / No	Yes / No
GP Name		
GP full address & Postcode		
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)	*	*
Date of signature	/ /	/ /

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			
No. of ectopic pregnancies			
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			
HEIGHT –			WEIGHT -