DANIEL BODRI
FERTILITY CONSULTING

PATIENT QUESTIONNAIRE

FEMALE PATIENT:

Given name:	Date of birth:
Last name:	Country of residence:
Nationality:	Full address:
Mobile phone:	Civil status:
Email:	Profession:

PARTNER (if applicable):

Given name:	Date of birth:
Last name:	Country of residence:
Nationality:	Full address:
Mobile phone:	Civil status:
Email:	Profession:

How did you hear about us?

Referring doctor:
Friends
Internet
Social media
Others
Reference gynaecologist:

Why you wish to contact us:

Fertility assessment
Fertility treatment (OI, IUI, IVF, PGT-A)
Egg freezing
Egg recipient treatment

How long have you been trying to get pregnant:
Intended period to perform treatment:

ANAMNESIS FEMALE PATIENT:

Menstrual cycle history:

1st menstrual period:	Duration of bleeding:
Regular cycles?	Painful periods?
Duration of cycles:	Date of last bleeding:

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Obstetric history:

	Total number	Years	Details
Terminations			
Miscarriages			
Deliveries			
Children			

Previous fertility treatment (how many, years, details):

IUI:
IVF:
Egg recipient treatment:
Other:

Medical history (years, details)**:**

Medical conditions:
Surgeries:
Gynaecological issues:

Family history (which relative, what illness)**:**

Medications, allergies:

Drug allergies:
Regular medication (name/dose):

Smoking (no/ if yes, ? cigarettes/day):

Vaping (no/yes):

Alcohol (no/ if yes, ? units/day):

Recreational drugs (no/yes):

Physical characteristics:

Weight:		Hair texture:	
Height:		Blood type:	
Eye colour:		Ethnicity:	
Skin colour:		Observations:	
Hair colour:			

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ANAMNESIS PARTNER (if applicable):

Pregnancies/live births with current partner (how many, years, details):

Pregnancies/live births with previous partner(s) (how many, years, details):

Medical history (years, details)**:**

Medical conditions:
Surgeries:
Gynaecological issues:

Family history (which relative, what illness)**:**

Medications, allergies:

Drug allergies:
Regular medication (name/dose):

Smoking (no/ if yes, ? cigarettes/day):

Vaping (no/yes):

Alcohol (no/ if yes, ? units/day):

Recreational drugs (no/yes):

Physical characteristics:

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Eye colour:		Ethnicity:	
Skin colour:		Observations:	
Hair colour:			