



SERUM IVF SA
ADVANCED IVF TREATMENT CENTER

SOFOKLI VENIZELOU AVENUE 26, 141 23 LYKOVRYSI, ATTICA
TEL.: +30 210 7700744 FAX: +30 210 7489567
WEB: www.ivfserum.com EMAIL: info@ivfserum.com

PATIENT HISTORY QUESTIONNAIRE

Full Name	
Father's first name	
Mother's first name	
Date of Birth	
Home Address	
Telephone Home Landline	<u>N.B., it is sometimes efficient for us to give phone you on your landline in the evening e.g., 7-9pm Greek time rather than send an email. Please confirm if you are happy for us to phone you?</u>
Telephone Mobile	
E-mail address	
Profession	
Marital Status*	

FERTILITY HISTORY – FEMALE PATIENT

<p>Please describe your previous fertility history, including any pregnancies, miscarriages, previous fertility treatments & their outcomes. Please give dates.</p> <p>For fertility treatments please give a summary of the protocol (the medications and doses used, the duration of stimulation) and the number of eggs retrieved, and the number of embryos available and transferred.</p> <p>Please note if you experienced any unusual symptoms around implantation time (fever, sore throat, joint pain, skin rashes etc) and if you bled before the test date on any IVF cycles.</p>

--

FURTHER QUESTIONS – FEMALE PATIENT:

Do you have menstrual cycles/periods ?	
Are these cycles regular ?	
How long does your cycle last (from one bleeding to the next)?	
How long does the bleeding usually last ?	
Describe the bleeding – is it profuse and red ? Does it stop and start abruptly or is there brown spotting before the period or after the period?	
When do expect your next period to start ?	
Have you had a hysteroscopy, aquascan or laparoscopy ? Please give the date and the findings here.	
Do you take any drugs (including vitamins and supplements) regularly ? Please list here:	
Have you ever been diagnosed with any kind of immune problems ?	
Have you had your thyroid hormones tested? Please list TSH, FT4, antithyroid antibodies here.	
Please summarise here any recent results of FSH, LH, prolactin, AMH tests etc	
Have you ever been checked for clotting (thrombophilia) problems ? Please list the results here.	
Have you ever been checked for Chlamydia (PCR) ? Please list results here.	
Have you ever been checked for karyotyping ? Please list any abnormal results here.	

Have you ever been diagnosed with a viral infection (herpes, shingles, cold sores , HPV etc)?	
Please list any other fertility related test results with dates	
Please list any other health issues , including allergies and any previous operations that we should be aware of.	
Please give your height, weight and BMI	
Please indicate your ethnic origin	
Please give your hair colour and eye colour	
Please give your blood group if known	

HUSBAND / PARTNER - HEALTH INFORMATION

Full Name	
Father's first name	
Mother's first name	
Date of Birth	
Telephone	
Email	
Occupation	
How many children have you had ?	
Please list details here of any sperm analyses you have had done (with dates)	
Have you ever been checked for karyotyping ? Please list any abnormal results here.	
Have you ever been checked for cystic fibrosis gene mutations? Please list results.	
Please list any other health issues , including allergies and any previous operations that	

we should be aware of.	
Do you take any drugs (including vitamins and supplements) regularly ? Please list here:	
Please give your height, weight and BMI	
Please indicate your ethnic origin	
Please give your hair colour and eye colour	
Please give your blood group if known	

QUESTIONS:

Please list here any initial questions or concerns you may have regarding any treatment.	
---	--

- Please also note that according to the Greek law it is required that you bring before your medical treatment (IVF-IUI etc.) the below:

1. HIV 1 + 2 test – dated in last 6 months*
2. Syphilis test (VDRL or RPR) – dated in last 6 months*
3. Hepatitis B (HbsAg, HBcAb IgM) test – dated in last 6 months*
4. Hepatitis C (HCV) test– dated in last 6 months*
5. Cardiogram / ECG test report– dated in last 6 months (required only for patients intending Egg Collection or Surgical Sperm Retrieval)**

6. Marital status certificate we need to have a copy of this for our files as following. ***

- Married couples

Marriage certification

- Single lady

A valid certification signed by you in presence of a notary that you are undergoing IVF treatment declared a single lady with sperm donation responsible for the child / children conceived

- Partnership

A valid certification signed by both parties in presence of a notary that you are both undergoing IVF treatment declared / as partners responsible for the child / children conceived

7. Passport

1, 2, 3 & 4 are also required when the male partner wishes to cryopreserve semen.

*If you do not have items 1-4, we can arrange to do these tests for you for €110 per person.

For married and unmarried couples, regardless of whether sperm donation will be used, both partners must show proof of testing as this is a legal requirement.

**If you need us to arrange the ECG for you, please let us know.

***If you need us to arrange the relevant certification that applies for single ladies and couples in partnership we may organize this with a local notary at the cost of 100 euros.

**** **It is strongly suggested for:**

All women under 35 years old, a recent breast ultrasound

All women over 35 years old, a recent mammography

***** **It is strongly advised to secure travel medical insurance before your treatment.**

A highly recommended option is through www.medicaltravelshield.com.

By submitting this questionnaire, I hereby fully understand, accept and consent that my Personal data including all sensible personal data pertaining to my health which reveal information relating to my past, current or future physical/ mental health status will be stored in a medical file and are protected from unauthorized disclosure, distribution and processing under domestic and E.C. relevant Legislation. I also give my informed consent that sensible personal data from my medical file will be treated as confidential and can only in codified and classified format be disclosed to the National Authority of Medically Assisted Reproduction for statistic reasons and i consent to that in knowledge of my (consent) withdrawal right.

By completing this questionnaire, you consent to the IVF Serum Clinic contacting you on your telephone/ mobile numbers and / or emails you have stated above. If you wish to modify your personal information, you can contact the data protection officer at privacy@ivfserum.com.

PLEASE RETURN QUESTIONNAIRE TO info@ivfserum.com

MANY THANKS FOR YOUR TIME