**Donor Eggs Australia**
Summary of Female Patient Information

## Introduction

1. The following information has been requested by the respective overseas donor egg/sperm/embryo clinics for your preparation for their programmes and will be transmitted to them.
2. Please make every attempt to be as accurate and comprehensive as possible.
3. Where blood results are requested copies or originals of tests need to be provided. If the test is out of date or needs to be repeated you will be informed and appropriate test request forms will be provided.
4. You will require a referral from your General Practitioner made out to Dr Joel Bernstein for BOTH PARTNERS, preferably for an indefinite period.
5. When filling in the form please cross Yes No answers and if a number is required even if zero please fill in a zero rather than leaving blank.
Some examples are provided and these will be in Italics.
6. Please post or deliver by hand the completed forms and copies of results

## Postal Address

Denyse Asher
Suite 502, Harley Place
251 Oxford Street
Bondi, Junction
Sydney
NSW 2022

**Donor Eggs Australia**
Summary of Female Patient Information

**Information**

**FEMALE**

**Identification**

| | |
|---|---|
| Surname | |
| First & Middle Names | |
| Date of birth | Day Month Year |
| | |
| Current Age | |
| | |
| Country of birth | |
| | |
| Country of present residence | |
| | |
| Occupation | |
| Telephone Home | |
| Work | |
| Mobile | |
| E mail | |
| Passport Nationality | |
| Passport Number | |
| | |

**Physical Characteristics**

| | |
|---|---|
| | |
| Racial Group | |
| Eye colour | |
| Hair colour | |
| Height (cm) | |
| Weight (Kg) | |
| Blood Group | |
| Rh | |
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**Menstrual History**

How old were you when you had your first menstrual period? Years

Do you still have menstrual periods? Yes No

*If your answer is **NO**, please answer the following:*

When did you last have a period? Months Years

Were you tested once your periods stopped, and told the cause?

*If you know the cause please fill in the space below.*

*If your answer is **YES**, please answer the following:*

Are your periods regular? Yes No

*Regular periods occur every month, the timing may vary by a few days such as 28± a few days.*

*If your answer is **YES**, please answer the following:*

How many days on average of normal/full bleeding do you have each month? Days
*Average means taking the length of say the last 3 cycles eg 5,6,4 days =average 5days.*

How long are your average menstrual cycles? Days
*From the 1st day of proper bleeding to the next first day of proper bleeding*
*Average means checking last few cycles 28,30, 29. Average = 29 days.*

During your menstrual periods do you pass blood clots? Yes No
*Clot is a thick lump of blood*

Over the last few months has the average number of days of bleeding increased? Yes No

*If your answer Is **N0**,(no regular periods) please answer the following:*

Describe the shortest and longest gaps between menstrual cycles. to
*Example 19 to 38 days*

Do you regularly miss months between menstrual cycles? Yes No

Do you have period pain? Yes No

Does your period pain begin before the bleeding? Yes No

| | | |
|---|---|---|
| Does the pain last during the actual bleeding? | Yes | No |
| Does the pain continue after the bleeding has stopped? | Yes | No |
| How severe is your menstrual pain? | | Mild |
| | | Moderate |
| | | Severe |

*Mild:* *Still able to go about your daily routine, no medication*
*Moderate:* *Able to go about daily routine, but requires medication*
*Severe:* *Unable to go about daily routine, requires or requires bed rest of medication.*

Name of medication used for period pains

| | | |
|---|---|---|
| Has the severity/intensity of the period pain increased over the last 3-6 months? | Yes | No |
| Over the last 3-6 months has the number of days you suffer period pain per cycle increased? | Yes | No |
| Do you suffer pain when you go to the toilet to empty your bowel? | Yes | No |
| Have you developed spot bleeding for a few day before your proper menstrual bleeding begins? | Yes | No |
| For a few days prior to the onset of menstruation do you have any or any combination of sensitive/tender breasts, abdominal bloating or swelling, lower abdominal discomfort? | Yes | No |
| Do you experience pain in the lower abdomen on either side or possibly alternating each month, which occurs approximately 2 weeks before your menstrual period is due? | Yes | No |

*This pain usually lasts for 1-3 days*.

| | | |
|---|---|---|
| Do you experience an increased secretion of mucus/fluid from the vagina approximately 2 weeks before your menstrual cycle begins? | Yes | No |

## Contraception

Have you used any form of contraception or method to prevent pregnancy? Yes No

Have you used an intrauterine contraceptive device? Yes No
*Intrauterine device is a small plastic or metal object placed in the uterus to prevent conception. It has been produced in many shapes such as ring , coil, spiral, "t" shaped, "s" shaped etc.*

Did this intrauterine contraceptive device have to be removed because of complications such as infection or abnormal bleeding, fever, severe period pain or discharge? Yes No

Have you used any form of hormonal injection for contraception? Yes No

If yes, when did you have the last injection? Years Months

Have your menstrual cycles returned to normal? Yes No

## Pregnancy

Have you ever been pregnant? Yes No

*To answer this question correctly, a pregnancy is defined as a positive pregnancy blood test, or the presence of a foetus on ultrasound, or the confirmation of pregnancy tissue by a pathologist after removal of the tissue surgically, a pregnancy in a site other than the uterus (ectopic or tubal),or the birth of a formed infant even if premature or stillborn*.

*If your answer is **YES** then continue to answer the Questions below, if **NO** proceed to **PELVIC INFLAMMATORY DISEASE***

### Pregnancies with your present husband or partner

*If any of your answers to the questions are negative, for example you have never had any Caesarean sections please write a 0, but don't leave any blanks*

Have you ever been pregnant with your present husband or partner? Yes No

*If your answer is **YES** then continue to answer the questions, if **NO** proceed to **Pregnancies with other partners.***

How many times have you been pregnant? Number

How many live births have you had? Number

How many Caesarian sections? Number

How many pregnancies ended as a miscarriage or abortion less than 12 weeks? Number

How many pregnancies ended as a late miscarriage between 12 to 24 weeks? Number

Have any of your pregnancies ended as a stillbirth? Yes No

Have you ever had a termination of pregnancy? Yes No

Ages of your living children?
*Example, 7years 5 years etc.*

Approximate date of your last pregnancy?

## Pregnancies with other partners

*If any of your answers to the questions are negative, for example you have never had any Caesarian sections please write a 0,but don't leave any blanks*

Have you ever been pregnant with another husband or partner? Yes No

*If your answer is **YES** then continue to answer the Questions below, if **NO** proceed to **Pelvic Inflammatory Disease.***

How many times have you been pregnant? Number

How many live births have you had? Number

How many Caesarian sections? Number

How many pregnancies ended as a miscarriage or abortion less than 12 weeks? Number

How many pregnancies ended as a late miscarriage between 12 to 24 weeks? Number

Have any of the pregnancies ended as a stillbirth? Yes No

Have you ever had a termination of pregnancy? Yes No

Ages of your living children?

*Example: 7years 5 years etc*.

Approximate date of your last pregnancy?

**Pelvic Inflammatory Disease**

Have you ever suffered from pelvic inflammatory disease (PID)? Yes No

*Pelvic inflammatory disease is an infection of the uterus tubes and ovaries, being a serious infection and requiring antibiotic treatment and occasionally a stay in hospital. It does not refer to a simple vaginal discharge.*

Have you ever had peritonitis? Yes No

*Peritonitis is an inflammation of the lining of the abdominal cavity and an extremely serious condition. It would normally only be treated in hospital.*

Have you ever been treated for a sexually transmitted or venereal disease?

| STD | Yes | No |
|---|---|---|
| Syphilis | | |
| Gonorrhoea | | |
| Chlamydia | | |
| Herpes | | |
| HIV / AIDS | | |

**PAP SMEAR (**Papanicolau Smear Test)

Have you ever had a PAP smear test? Yes No

*A PAP smear is a test taken from the cervix to diagnose changes in the cervical cells which may lead to cervical cancer and is used in its prevention.*

Have you ever had an abnormal PAP smear result? Yes No

Has this been treated? Yes No

Are you now considered well? Yes No

**Breast**

Have you ever had a breast lump? Yes No
Have you ever had a mammogram? Yes No

If yes date of last mammogram? Years Months
Have you ever had breast cancer? Yes No

Additional Information regarding breast lump or cancer:

## MEDICAL HISTORY

### Illnesses:

Do you suffer from any disease of the heart, lungs, Intestinal tract, kidneys, bladder, immune system, nervous system or other any other system? Yes No

Do you suffer from any type of endocrine disease? Yes No
*(Diseases affecting the thyroid, parathyroid, adrenal or pituitary glands including diabetes?)*

Have you suffered from any tropical diseases eg malaria? Yes No

Have you suffered from TB (tuberculosis)? Yes No

Please fill in the name/nature of any of these diseases / illness (s)?

| Type/nature of Illness | Treatment Yes | Treatment No |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

### Allergies:

Are you allergic to any form of medication? Yes No
Please list the medication(s) and its generic name if possible:
*Use the generic names where possible ie the actual drug name rather than the trade name.*

| |
|---|
| |
| |
| |

**Birth Defects:**

Were you born with any birth defects or abnormalities? Yes No

*Please describe below:*

| |
|---|
| |
| |
| |

## CURRENT MEDICATION

Are you taking any form of medication at present? Yes No

*Please fill in the name(s) of the medication you take. Use the generic names where possible ie the actual drug name rather than the trade name.*

| |
|---|
| |
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| |

Are you taking any form of herbal medicine or vitamins? Yes No

*Please fill in the name(s) of the medication you take. Use the generic names where possible ie the actual drug name rather than the trade name.*

| |
|---|
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| |

## SURGICAL HISTORY

Have you ever had any type of operation or surgical procedure from the time you were born up till the present time? Yes No

*If no please proceed to the next question*.

If yes:

| Date | Type of Operation |
|---|---|
| | |
| | |
| | |
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| | |

I have included a list some of the relevant operations, which include:

*Curettage (D&C) operation performed through the vagina and cervix to remove the lining of the uterus.*
*Laparoscopy keyhole surgery using operating telescope inserted into the abdominal cavity usually via the umbilicus and allows the operator to see inside the abdominal cavity, and pelvis*
*Hysteroscopy surgery where a telescope is passed via the vagina into the uterus to check the cavity of the uterus. For this procedure no cuts are made.*
*Sterilisation procedure either performed through laparoscopy or laparotomy in which the Fallopian tubes are blocked or cut to prevent conception.*
*Laparotomy an operation in the abdominal or pelvic cavity performed through a cut in the abdominal wall*
*Oophorectomy removal of an ovary*
*Ovarian cyst removal or drainage of an ovarian cyst*
*Salpingectomy removal of a Fallopian tube*
*Adhesiolysis freeing of adhesions in the pelvic cavity especially those affecting the uterus, tubes and ovaries*
*Surgery for endometriosis either by laparoscopy or laparotomy to remove endometriosis of the reproductive tract*
*Appedicectomy removal of the appendix*
*Operation on the bladder or ureters*
*Cancer surgery for cancer anywhere on the body.*
*Operations anywhere on the body even those not related to fertility*

Where you told after your last surgery whether the following organs are normal?

| Organ | | Yes | No | Don't know |
|---|---|---|---|---|
| Uterus | Normal | | | |
| Right ovary | Normal | | | |
| Right tube | Open | | | |
| Left ovary | Normal | | | |
| Left tube | Open | | | |

**PLEASE PROVIDE A COPY OF THE SURGICAL REPORT AND PATHOLOGY WHERE POSSIBLE, ESPECIALLY FOR SURGERY IN THE LAST 3 YEARS.**

## FAMILY HISTORY

Have any of your children had birth defects (congenital abnormalities) Yes No

| Male | Female | Type of Birth Defect |
|---|---|---|
| | | |
| | | |

Has anyone in your family had children with birth defects or a child who has died in the first few weeks of life. Yes No
If yes please supply details including their relationship with you, example, brother, sister or cousin.

| Relationship | Birth Defect |
|---|---|
| | |
| | |
| | |

Does anyone in the family have a genetic /inherited condition? Yes No

Has anyone in the family had multiple miscarriages? Yes No
*This means 3 or more consecutive miscarriages*

Have any members of your family on both your mother and/or father's side had cancer of the ovary or breast ? Yes No

Have any members of your family on your mother or father's side had Polycystic Ovarian Syndrome (PCO)? Yes No

Have any members of your family suffered with Non insulin dependent diabetes, (Type 2 diabetes, or late onset/adult onset diabetes)? Yes No

Have any members of your family suffered with infertility? Yes No
What are their relationships with you? (Brothers, Sisters):

| Brother | Sister | Cause of infertility if it is Known |
|---|---|---|
| | | |
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## GENERAL & SOCIAL HISTORY

What is your occupation?

| |
|---|
| |

Has your occupation brought you into long term contact with toxic chemicals, ionising radiation or microwave irradiation? Yes No

If yes or you are not sure please describe anyway:

| |
|---|
| |

Do you smoke tobacco in any form? Yes No

Do you smoke marijuana? Yes No

Do you take any habit-forming drugs? Yes No

Do you drink alcohol? Yes No

If yes:

| Amount (average) | Per day | Per week |
|---|---|---|
| Wine glasses | | |
| Beer glasses | | |
| Spirits tots | | |

Do you perform any exercise over and above that required by your daily home or work routines or duties? Yes No

If yes:

30 Minute Sessions

| | |
|---|---|
| Less than 3 times per week | |
| 3 times per week | |
| More than 3 times per week | |

## SEXUAL HISTORY

How often do you have sex per week on average?

| | |
|---|---|
| Less than 1 | |
| 1 to 2 | |
| 2 to 3 | |
| 3 to 4 | |
| More than 4 | |

Do you attempt to time sex during the fertile time of your cycle? Yes No

If YES, over which days of your menstrual cycle do you try? Days to

*(See chapter in e Book, "Yes we can have a baby" for correct time to try and time intercourse). www.pathways-to-pregnancy.com. Example days 12 to 16*

Is sex painful? Yes No

If yes, is the pain superficial ie felt on the entrance to the vagina? Yes No

And / or is it deep inside the pelvis Yes No

If deep is it worse on any particular side? L R B
(L = left, R= right or B= both, if both sides)

Is the pain on intercourse worse at any particular time of your menstrual cycle?

| | |
|---|---|
| Early in your cycle | |
| Around midcycle (ovulation time) | |
| Later, leading up to your period | |

**FERTILITY AND OTHER TESTS**

BLOOD TESTS

These include hormone levels, full blood count and chemistry, infection screen for Hepatitis A, B & C, HIV and HTLV, Chlamydia, Syphilis, Gonorrhoea, chromosomes/karyotype, cystic fibrosis, fragile x, CA 125, and natural killer cells (NK Cells)

Have you undergone testing for recurrent miscarriage? Yes No

*PLEASE ATTACH COPIES OF ALL BLOOD TESTS PERFORMED IN THE LAST YEAR. If in doubt attach results!*

- PELVIC ULTRASOUND
- HYSTEROSALPINGRAM
- FLUID SONOHYSTEROGRAM
- HYCOSY
- CAT SCANS (INCLUDING PITUITARY)
- BREAST SCAN OR MAMMOGRAM

*PLEASE ATTACH COPIES OF ANY OF THESE TESTS YOU HAVE HAD, IRRESPECTIVE OF WHEN THEY WERE DONE.*

**SURGERY**

- HYSTEROSCOPY
- LAPAROSCOPY
- MYOMECTOMY
- D&C / CURRETTAGE
- LAPAROTOMY
- OTHER SURGICAL PROCEDURES

*PLEASE ATTACH COPIES OF ANY OF THESE TESTS YOU HAVE HAD, AS WELL AS ANY RELEVANT PATHOLOGY REPORTS e.g. BIOPSIES, IRRESPECTIVE OF WHEN THEY WERE DONE.*

**COUPLE**

CAUSE(S) OF INFERTILITY GIVEN TO YOU TO DATE
*Please fill in any reason(s)/causes for infertility that your doctors may have given you.*

| | |
|---|---|
| **1** | |
| **2** | |
| **3** | |
| **4** | |
| **5** | |
| **6** | |
| **7** | |

# TREATMENT OPTIONS ATTEMPTED

The following treatment options are available and if you have tried any of these please fill in the relevant ones.

## OVULATION INDUCTION

*This treatment option only involves the female partner taking medication to stimulate ovulation and the couple are advised when to have normal intercourse.*

| Date | Medication **CC** | Medication Gonadotr | HCG Trigger | Progesterone test | Pregnant | Not Pregnant |
|---|---|---|---|---|---|---|
| *12.3.2003 Example* | | *X* | *X* | *X* | *X* | |
| | | | | | | |
| | | | | | | |
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Information for filling in the form;
*The first row is an **EXAMPLE** and means date **12.3.2003,** the drug used was a gonadotropin **X,** an HCG trigger was used **X,** a progesterone test confirming ovulation was taken **X**, and a pregnancy resulted **X.***

| | |
|---|---|
| CC | Clomiphene citrate (Clomid, Serophene) |
| GONADOTR | Gonadotropin injections (Puregon, Gonal F) |
| TRIG | HCG trigger to stimulate egg release (Pregnyl, Ovidrel) |

Progesterone test Progesterone blood test to confirm ovulation

## OVULATION INDUCTION & INSEMINATION OF SPERM

*This treatment option requires that the female partner takes medication to stimulate ovulation and the male partner's sperm sample is inseminated into her vagina or uterus by the fertility specialist (or staff)*

| Date | Medication **CC** | Medication **Gonad** | Trigger **HCG** | Sperm prep | Insemination **Vagina** | Insemination **Uterus** | P4 | D | Pregnant |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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Information for filling in the form;
*Fill in blocks with an X where appropriate*

| | |
|---|---|
| CC | Clomiphene citrate (Clomid, Serophene) |
| Gonad | Gonadotropin injections (Puregon, Gonal F) |
| Trigger HCG | HCG injection to stimulate egg release (Pregnyl, Ovidrel) |
| Sperm prep | A procedure where the sperm sample is prepared/washed in a laboratory prior to insemination into the uterus |
| Insemination | This procedure involves the fertility specialist (or staff) placing the sample of sperm into the vagina (Vag) or into the uterine cavity (uterus) |
| P4 | Progesterone blood test to confirm ovulation |
| D | Indicates the use of Donor Sperm |
| Preg | Indicate with a Y or N whether or not this treatment cycle led to a pregnancy |

## ASSISTED REPRODUCTION (IVF, ICSI, GIFT AND FER)

| Date | Type of Treatment | Type of Treatment | Type of Treatment | Type of Treatment | **Eggs** | **Embryo(s) T/f** | **Embryo(s) T/f** | Pregnancy | Live B |
|---|---|---|---|---|---|---|---|---|---|
| | IVF | ICSI | GIFT | FER | | Fresh | Frozen | | |
| ***25.3.2002*** | ***X*** | | | | ***6*** | ***2*** | ***1*** | | |
| | | | | | | | | | |
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*The example indicates that in March 2002 this couple had an IVF attempt in which 6 eggs were collected, 2 embryos were put back into the uterus,1 embryo frozen, no pregnancy or live birth occurred.*

Information for filling in the form;

*Please fill in the date column*
*Those columns whose headings are **Bold** the actual numbers need to be filled in! (0, 1, 2…)*

| | |
|---|---|
| IVF | In Vitro Fertilisation attempts |
| ICSI | Intracytoplasmic Sperm Injection attempts |
| GIFT | Gamete Intrafallopian Transfer attempts |
| FER | Frozen Embryo Replacements – these attempts |

| | |
|---|---|
| Preg | Means the number of living foetuses present on first pregnancy ultrasound examination often done between 6&12 weeks of pregnancy. It does not include a positive pregnancy test followed by a menstrual bleed and no ongoing pregnancy. |
| LiveB | This means the number of live children resulting from this treatment cycle. |

IF ANY OF YOUR ART ATTEMPTS SHOWN ABOVE, INVOLVED USING DONOR EGGS, SPERM OR DONOR EMBRYOS THEN PLEASE FILL IN THE DETAILS BELOW SO WE CAN IDENTIFY WHICH OF THE ABOVE CYCLES INVOLVED DONOR?

| DATE | DONOR EGG | DONOR SPERM | DONOR EMBRYO |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have there been any problems related to ART? :

| | | |
|---|---|---|
| Hyperstimulation syndrome | Yes | No |
| Difficult embryo transfer requiring ultrasound or theatre | Yes | No |
| Has this problem been overcome | Yes | No |
| Problems relating to poor thickness of the endometrial (uterine lining) | Yes | No |

**Additional information that you feel is necessary**

**Photograph**

Please email one current photo of both you and your partner and children if available to denyseb@optusnet.com.au The file size should not exceed 250Kb

**Disclaimer**

The information that you have provided is to the best of your knowledge accurate and up to date. In Australia this information is dealt with within the dictates of the Privacy Act. This information is being transmitted to the relevant clinic and neither I Denyse Asher or Dr Joel Bernstein / Dr Joel Bernstein pty. Ltd. can be held responsible for this information once transmitted or stored overseas.

**Signature** **Name**

**Date**

**Check list:**
**1 Form completed and signed**
**2 Photo sent**
**3 Copies of tests, results and outcomes included.**