DONOR EGGS AUSTRALIA
DONOR EGGS AUSTRALIA PTY LTD
ABN 25627752783

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Donor Eggs Australia

FEMALE HISTORY

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, scan reports, Genetic Tests 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 If the test is out of date or needs to be repeated you will be informed and appropriate test request forms will be provided by Donor Eggs Australia.

4. Please use Black Ink only to fill out the forms.

4. When filling in the form please cross Yes or No answers and if a number is required,even if zero, please fill in a zero rather than leaving blank. *Examples are in Italics*.

5. Please post or email your completed forms to the address below.

6. Nikki and Denyse have their mobiles and e-mail on the letterhead above R.

Postal Address

Donor Eggs Australia
52 Gilgandra Road
North Bondi
Sydney
NSW
2026

FEMALE INFORMATION

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	

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 Days ( )

Average means taking the length of say the last 3 cycles
e.g. 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 **NO**,(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

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 feel ovulation pain Yes No
Pain which occurs 10-14 days before your menstrual period is due?

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)?

		Treatment
Type/nature of Illness	Yes	No
1		
2		

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.

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.

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

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

Were 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

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

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

1. 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!*

2. TESTS OF UTERUS AND TUBES

- 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.*

3. 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.

TREATMENT		PREGNANCY	MISCARRIAGE	LIVE BIRTH
Ovulation Tracking (OT)				
Ovulation Induction (OI)				
OI + Intrauterine Insemination (OI+IUI)				

OVULATION TRACKING
Ovulation tracking undertaken by fertility clinic using blood or urine tests and ultrasound.

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.

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)

ASSISTED REPRODUCTION (IVF, ICSI, GIFT AND FER)

Date	**Type of treatment**	**Outcome**

Date	IVF	ICSI	Frozen Embryo Transfer	Eggs	Embryo Transf.	Embryo Freeze	Pregnant	Live Birth
25.3.19	***X***			***6***	***2***	***1***	**0**	

The example indicates that in March 2019 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**;*

IVF *In Vitro Fertilisation*
ICSI *Intracytoplasmic Sperm Injection*
FER *Frozen Embryo Replacements – these attempts*
Pregnant *Means the number of living foetuses present on first pregnancy ultrasound examination often done between 6&12 weeks of pregnancy. It does NOT include Biochemical Pregnancy*
LiveBirth *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

Any additional information that you feel is relevant:

Donor Eggs Australia

Summary of Female Patient Information

Photograph

Please email one current photo of both you and your partner and children if available to denyseb@donoreggsaustralia.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 Donor Eggs Australia or its professional associates can be held responsible for this information once transmitted or stored overseas.

Signature **Name**

Date

Checklist:

Forms Completed and Signed	**Photo sent**	**Copies of tests, results and outcomes included**