



MEDICAL HISTORY

FEMALE PARTNER to complete NAME: _____ D.O.B. ___/___/___

Have you ever smoked? CURRENTLY PREVIOUSLY NO . If yes how many per day _____

Do you consume alcohol? YES NO

If "yes" please indicate how many glasses per week _____

Are your periods: REGULAR (beginning every 21 – 38 days) IRREGULAR ABSENT

Are you taking any regular medication / herbal remedies? YES NO

If "yes" please record _____

Have you had any previous surgery? YES NO

If "yes" please specify _____

Have you had a general anaesthetic in the past? YES NO

Please record details of any problems with this. _____

Significant Medical History: Asthma Diabetes Epilepsy High blood pressure
 Other _____

MALE PARTNER to complete NAME: _____ D.O.B. ___/___/___

Have you ever smoked? CURRENTLY PREVIOUSLY NO . If yes how many per day _____

Do you consume alcohol? YES NO

If "yes" please indicate how many glasses per week _____

Are you taking any regular medication / herbal remedies? YES NO

If "yes" please record _____

Have you had any previous surgery? YES NO

If "yes" please specify _____

Have you had a general anaesthetic in the past? YES NO

Please record details of any problems with this. _____

Significant Medical History: Asthma Diabetes Epilepsy High blood pressure
 Other _____