APEX
Reproductive Healthcare Ltd

P: 020 3750 0111
E: info@apexfertility.co.uk
W: apexfertility.co.uk

NEW PATIENT INFORMATION FORM

The information requested in this form is collected to provide personalised, effective treatment. This includes medical histories, current health conditions, and lifestyle factors, which are crucial for diagnosing issues and tailoring treatment plans.

Additionally, personal details like age, occupation, and contact information are necessary for administrative purposes and ongoing communication. Your information is stored securely and access is restricted to authorised personnel only.

PERSONAL DETAILS

Title (Mr./Mrs./Ms...):	
Full Name:	
Ethnicity:	
Date of Birth (DD.MM.YYYY):	
Weight (kgs):	
Height (cms):	
Occupation:	
Passport/ID Number:	
Country of Birth:	
Nationality:	
Relationship Status:	☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow/Widower ☐ Single ☐ Cohabiting

YOUR CONTACT DETAILS

Phone Number/Numbers: (Please provide atleast one - select your preferred contact number)	☐ Home: ☐ Mobile: ☐ Work:
Email Address:	
Address: (Please provide full address with postcode)	

EMERGENCY CONTACT DETAILS

Contact Name:	
Relationship to You:	
Contact's Phone Number:	

GP DETAILS

GP Name:	
Surgery Name:	
Phone Number:	
GP's Surgery Address:	

INSURANCE DETAILS

Insurance Company:	
Member's Name:	
Membership Number:	
Authorisation Code:	

COMMUNICATION CONSENT

All emails from us are protected from unauthorised access & activity

I consent to receiving emails from Apex Reproductive Healthcare Ltd:	☐ Yes ☐ No
I consent to sharing my test results with my partner:	☐ Yes ☐ No Partner's name:
Your Signature:	

MEDICAL HISTORY

Reason for Consulting Dr. Vidya Seshadri:

Menstruation Details	
At what age did you start your period?	
Do you normally have painful periods?	
Do you normally have heavy periods?	
How many days does your period last?	
Do you bleed inbetween your periods?	
How often do you get your period? (Calculate from the first day of bleeding, till the last day before you start bleeding again)	

Do you have or have you ever had any of the following?	
☐ Diabetes	☐ Raised BMI
☐ High or low blood pressure	☐ Bleeding after intercourse
☐ High cholesterol	☐ Pelvic infections
☐ Anaemia	☐ Sexually transmitted disease
☐ Heart conditions	☐ Gynaecological conditions like fibroids, PCOS, or endometriosis
☐ Cancer	☐ Asthma
☐ Tuberculosis	☐ Other
If you have selected any of the above, provide details if possible:	

Have you ever had any minor or major surgery? If yes, please provide details below	
Pap Smear Test	
When was your last test?	
What was the result?	☐ Normal ☐ Abnormal
Do you have any allergies? Please provide details below	
Are you on any medication? Please provide details below	
Do you have a family history of any medical conditions? Please provide details below	

Have you ever been pregnant?	
How many times?	
Dates of each pregnancy:	
What were the outcomes?	

Lifestyle	
Do you smoke? ☐ Yes ☐ No	Do you drink more than 2 cups of coffee or tea per day? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No	Is your diet heavy on carbs, sugar, and fats? ☐ Yes ☐ No
Do you get bwetween 6 to 8 hours of sleep every night? ☐ Yes ☐ No	Do you walk/exercise for atleast an hour everyday? ☐ Yes ☐ No

Thank you for taking the time to fill out this form.