APEX
Reproductive Healthcare Ltd

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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./Master):	
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

To ensure your privacy and adhere to General Data Protection Regulations, all clinical correspondence will be encrypted using **Proton Email**:

1. You will receive an encrypted email prompting you to create a **Proton secure email account**, which **only needs to be done once**.
2. For any future emails, you will simply need to log into your account to access them.

Please note that we cannot send clinical information unencrypted unless you provide a written request to opt out of encrypted emails.

I consent to receiving only encrypted emails from Apex Reproductive Healthcare Ltd:	☐ Yes ☐ No

If you have selected 'No', Apex Reproductive Healthcare Ltd will not be held responsible for any security breaches or unauthorised access to your information in the unencrypted emails exchanged between you and Apex Reproductive Healthcare Ltd.

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:

- ☐ Recurrent miscarriages
- ☐ Fertility check-up
- ☐ Trying to conceive for ..... years (please specify number of years)
- ☐ Primary infertility (no prior pregnancies)
- ☐ Secondary infertility (previous pregnancies in the current relationship)
- ☐ Secondary infertility (previous pregnancies in a different relationship)
- ☐ Fertility preservation for social reasons
- ☐ Fertility preservation for medical reasons
- ☐ PGD to lower the risk of genetic disorders
- ☐ Sperm donation
- ☐ Single individual
- ☐ Same-sex couple

Medical Details	
Have you ever had mumps?	☐ Yes ☐ No
Have you ever been exposed to the following??	☐ Radiation ☐ Chemicals ☐ Extreme Heat ☐ Pesticides
Do you have difficulties during intercourse?	☐ Pain ☐ Penetration ☐ Erection ☐ Ejaculation
Have you ever experienced testicular torsion (twisting of a testicle)?	☐ Yes ☐ No
Have you ever been diagnosed with Varicocele?	☐ Yes ☐ No
Are you using contraceptives? (if yes, please provide details)	

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	☐ Impotence
☐ Anaemia	☐ Sexually transmitted disease
☐ Heart conditions	☐ Conditions like Klinefelter Syndrome or Y Chromosome Microdeletions
☐ 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

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 (diabetes, heart condition, high blood pressure etc? Please provide details below

REPRODUCTIVE HISTORY

Have you fathered any children in a previous or current relationship?	☐ Yes ☐ No
Is/are the child/children healthy? (if no, please provide details)	

FERTILITY TREATMENT HISTORY

Have you ever had fertility treatments before?	☐ Yes ☐ No

If yes, please provide details below:

	1st treatment	2nd treatment	3rd treatment	4th treatment	5th treatment
Treatment name					
Year of treatment					
Treatment provider					
Treatment outcome					

Do you currently have any frozen eggs, sperm, or embryos stored elsewhere?

☐ No ☐ Sperms ☐ Eggs ☐ Embryos

Please provide the location of samples:

LIFESTYLE

Do your smoke?	☐ Yes ☐ No
If yes, how many cigarettes/cigars per day?	
Do you drink alcohol?	☐ Yes ☐ No
If yes, how many units per week?	
Do you drink caffeine?	☐ Yes ☐ No
If yes, how many cups per day?	
Do you take recreational or performance-enhancing drugs?	☐ Yes ☐ No
If yes, provide details & frequency of use:	
Have you travelled overseas in the last 6 months?	If yes, please provide details:
Do you suffer from poor digestion?	☐ Yes ☐ No
Do you take any nutritional supplements?	If yes, provide details:

CONTINUATION SHEET