Advanced Fertility Center
Cancun

QUESTIONNAIRE FIRST VISIT

First Language: _____

Date: _____

1. PERSONAL INFORMATION

Patient Full Name & Surname: _____ Date of Birth: _____ Age: _____

Citizenship: _____ Blood type: _____ Height: _____ Weight: _____

Husband/Partner Full Name & Surname: _____ Date of Birth: _____ Age: _____

Citizenship: _____ Blood type: _____ Height: _____ Weight: _____

2. CONTACT INFORMATION

Home Address: _____ Cellular: _____

Email address: _____ Tel. Home: _____ Tel. Office: _____

Referred by: _____ Family Physician: _____

Clinic/Hospital: _____ Address: _____ Telephone: _____

3. MEDICAL HISTORY OF FEMALE PARTNER

GYNAECOLOGICAL HISTORY

At what age did your menstrual periods start? _____

Do you still have periods? _____

If no, are you menopausal? _____

If yes, do you take hormone replacement therapy? _____

Date of last period: _____

How long did it last? _____

Are your periods regular? _____

How many days in between your periods? _____

Do you have painful periods? _____

Do you have any bleeding in between your periods?
If yes, explain: _____

Do you have vaginal discharge, in general?
If yes, explain: _____

Do you experience discomfort during intercourse?
If yes, explain: _____

On when was your last PAP smear? Date: _____
Please explain the findings: _____

Have you ever had an abnormal PAP smear result? Y/N: _____
If yes, explain: _____

Do you use contraception? Y/N: _____
If yes, what type? _____

Do you have any problems with passing urine? Y/N: _____
If yes, explain: _____

Do you have any problems with your bowels? Y/N: _____
If yes, explain: _____

Have you ever made a hysterosalpingography test? Y/N: _____
If yes, explain results: _____

Have you ever made a serology test for infectious diseases? Y/N:
_____ VIH, Hepatitis B, Hepatitis C, VDRL (sífilis)
If yes, explain results and date of the last test: _____

Have you ever made a hormone profile test? Y/N: _____
If yes, explain results and date of the last test: _____

Ave. Tulum, Lt 3, Mz 1
SM 9, On the ground floor
C.P. 77500, Cancun, Quintana Roo
www.fertilitycentercancun.com

Telephone: (998) 889-92-50
(998) 889-92-64
(998) 802-21-97
(998) 802-21-98
(998) 802-21-99

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OBSTETRIC HISTORY

Are you Currently Breastfeeding? Y/N: _____ For how long? _____

Number of pregnancies: _____ Dates: _____ Number of termination of pregnancies: _____ Dates: _____

Suspicion of miscarriages? _____ Number of miscarriages: _____ Dates: _____

Number of children: _____ From this relationship: _____ From a previous relationship: _____

Male /Female	Delivery Date	Complications (during pregnancy)	Height / Weight	

MEDICAL HISTORY

Do you have any allergies? Y/N: _____ Please, explain: _____

Do you have any current medical condition? _____ Please, explain: _____

Are you currently taking any medication? Y/N: _____ Prescribed or over the counter: _____

_____ Medicine: _____ Dates: _____

Have you had hospitalisation for any medical condition? Y/N: _____ Please, explain: _____

SURGICAL HISTORY

Have you had surgeries? Y/N: _____ Please explain date and what for: _____

_____

_____

_____

FAMILY HISTORY

Are there any specific medical conditions within your family?
Please, explain: _____

_____

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QUESTIONNAIRE FIRST VISIT

Of the following, please mark if they are present which member of your family:

- ☐ Heart Conditions _____
- ☐ Blood Conditions _____
- ☐ Respiratory _____
- ☐ Gastroinstestinal _____
- ☐ Metabolic/Endocrinological _____
- ☐ Urinary _____
- ☐ Skin Problems _____
- ☐ Genital _____
- ☐ Reproductive _____
- ☐ Mental _____
- ☐ Neurodegenerative _____
- ☐ Muscle/Bones/Joints _____
- ☐ Sight/Hearing/Olfative _____

SOCIAL HISTORY

What is your occupation? _____

Do you smoke? Y/N: _____ If yes, how many per day? _____

Do you drink alcohol? Y/N: _____ If yes, how often? _____

Do you do recreational drugs? Y/N: _____ If yes, what type and how often? _____

4. MEDICAL HISTORY FOR MALE PARTNER

MEDICAL HISTORY

Do you have any allergies? Y/N: _____ Please, explain: _____

Do you have any current medical condition? _____ Please, explain: _____

Have you had hospitalisation for any medical condition? Y/N: _____ Please, explain: _____

Are you currently taking any medication? Y/N: _____ Prescribed or over the counter: _____

Do you have children from other relationships? Y/N: _____ How many and their ages: _____

Have you ever made a serology test for infectious diseases? Y/N: _____
VIH, Hepatitis B, Hepatitis C, VDRL (sífilis)
If yes, explain results and date of the last test: _____

Have you ever made a sperm analysis? Y/N: _____

If yes, explain results and date of the last test: _____

SURGICAL HISTORY

Have you had surgeries? Y/N: _____ Please explain date and what for: _____

_____

_____

_____

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FAMILY HISTORY

Are there any specific medical conditions within your family?
Please, explain: _____

_____

Of the following, please mark if they are present which member of your family:

- ☐ Heart Conditions _____
- ☐ Blood Conditions _____
- ☐ Respiratory _____
- ☐ Gastroinstestinal _____
- ☐ Metabolic/Endocrinological _____
- ☐ Urinary _____
- ☐ Skin Problems _____
- ☐ Genital _____
- ☐ Reproductive _____
- ☐ Mental _____
- ☐ Neurodegenerative _____
- ☐ Muscle/Bones/Joints _____
- ☐ Sight/Hearing/Olfative _____

SOCIAL HISTORY

What is your occupation? _____

Do you smoke? Y/N: _____ If yes, how many per day? _____

Do you drink alcohol? Y/N: _____ If yes, how often? _____

Do you do recreational drugs? Y/N: _____ If yes, what type and how often? _____

5. FERTILITY HISTORY FOR BOTH PARTNERS

BOTH PARTNERS

How long have you been trying to conceive? _____

Please describe infertility problem: _____

Please describe the diagnostic tests and results of these: _____

Please describe infertility treatments (when, what, and detailed results): _____

What treatment are you planning to undergo at Advanced Fertility Center Cancun? _____

Do you require an egg donor? Y/N: _____

If so, please describe the desired physical features: _____

Do you require a sperm donor? Y/N: _____

If so, please describe the desired physical features: _____

Do you require a surrogate mother? Y/N: _____

If so, please describe the reason: _____

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ANY OTHER RELEVANT INFORMATION

_____

_____

_____

_____

DIAGNOSTIC TESTS RESULTS

Please send copies of all requested test results to Dr. Azul Torres | **atorres@fcc.com.mx**
Or via fax to the telephone number:

Fax
+ 1 (917) 791 83 23

THANK YOU!
WE'LL SEE YOU SOON

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