Centre for Reproductive Immunology and Pregnancy

Pre-Appointment History Sheet

Please fill in the below table with your details:

Title	
First Name	
Surname	
Date of Birth and age	
Occupation	
Do you smoke? (please circle)	Yes If yes, how many per day? ……. No
How is your alcohol intake (please circle)	None Low Moderate High
Are you on any regular medications?	
Do you have any allergies?	Yes Allergies: No

Please fill in the below table with your partner's details:

Title	
First Name	
Surname	
Date of Birth	
Occupation	
Do you smoke? (please circle)	Yes If yes, how many per day? ……. No
How is your alcohol intake (please circle)	None Low Moderate High
Are you on any regular medications?	
Do you have any allergies?	Yes Allergies: No

How long have you been with your partner? ……

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Children (Sex, Age, Name, Weight and delivery mode)	**Miscarriages**	**IVF/ICSI**	**Ectopic/Pregnancy of unknown location**	**Stimulated Cycles & medication used**	**Stillbirths**
		Fresh **Frozen** **Donor**			

Please fill in the below table with the number you have had for all those applicable:

Please fill in the below table for each pregnancy you have had in the order from your first to the latest:

(If you have had more than 5 then please, continue on the back of the sheet)

	1	**2**	**3**	**4**	**5**
Pregnancy Outcome Please circle	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child	Miscarriage Chemical pregnancy Ectopic Second Trimester loss Child
Year					
Type of conception Please circle	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation	Natural IVF/ICSI Superovulation
Gestation miscarriage diagnosed at					
Type of Miscarriage i.e complete/missed **Gestation miscarriage size**					
Management of Miscarriage Please circle	Natural ERPC Medical	Natural ERPC Medical	Natural ERPC Medical	Natural ERPC Medical	Natural ERPC Medical

Please fill in table below for any IVF attempts you may have had:

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	1	2	3	4	5
Type of IVF Please circle	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor	Fresh Frozen Donor
IVF/ICSI					
Where IVF done					
Year					
Number of eggs collected					
Number of fertilised embryos					
Number of embryos or blastocysts transferred					
Outcome Please circle	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt	Child Miscarriage Failed attempt

Please fill in table below with your gynaecological history:

Cycle length	
Number of days of bleeding	
Blood Loss Please circle	Light Average Heavy
Last Menstrual Period (Please leave blank for Mr Shehata to fill in)	
Do you get any bleeding between periods? Please circle	Yes No
Do you get any bleeding after intercourse? Please circle	Yes No
Do you get any pain during intercourse? Please circle	Yes No
Have you had any of the following investigations if so in what year: Please circle	Hysteroscopy Laparoscopy HyFosy HSG

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Have you had pelvic surgery for any of the following and if so in what year: Please circle	Fibroids Ovarian Cysts
Are you up to date with your cervical smears? Please circle	Yes No
Have you ever had an abnormal smear? Please circle	Yes No If yes in which year …… If yes how was it treated? ……..

Please fill in table below with your medical history:

Do you have any medical history of:	
Diabetes Please circle	Yes: Type I Type II No
Hypertension Please circle	Yes No
Glaucoma Please circle	Yes No
Thyroid Please circle	Yes No
Asthma Please circle	Yes No
Blood Clots Please circle	Yes No
Other medical issues	

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Do you take any multivitamins while you are trying?	If Yes please provide the name of them below:

Please fill in table below with your family history:

Do you have any family history of:	
Diabetes Please circle and if yes who and which type?	Yes – Type I ……. Type II ……. No
Hypertension Please circle and if yes who?	Yes - …… No
Glaucoma Please circle and if yes who?	Yes - …… No
Thyroid Please circle and if yes who?	Yes - …… No
Recurrent miscarriages Please circle and if yes who?	Yes - …… No
Other family history	

Please fill out the below table with your full address and contact details:

Full address:	

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Contact number:	
Partner's number:	
Email address:	

Please fill out the below table with your GP details

GP Surgery	
GP name	
GP surgery address	
GP telephone number	
GP fax number	
Would you like all correspondence to be copied to your GP Please circle	Yes No

To be completed by Mr Shehata at your appointment:

Investigations/Results **Date:**

Thrombophilia	Normal	Abnormal	Type of abnormality:		
Pre-Pregnancy	Normal	High			

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NK CD 16/56 Count NK CD 16/56%					
Pre-Pregnancy NK CD69	Normal	Borderline	High	Very High	
NK Cytotoxicity	Normal	High	Best Suppression IVIG	Best Suppression Prednisolone	Best Suppression Intralipid
TNFα	Normal	Abnormal			
TB Test	Negative	Equivocal	Positive		
Thyroid Antibodies	Normal	Weak Positive	Strong Positive	TPO	TGA
ANA	Normal	Weak Positive	Strong Positive		
Gliadin Antibodies IgG/IgA	Normal	Weak Positive	Strong Positive		
TFT	Normal	High TSH only	Abnormal		
Prolactin	Normal	Abnormal			
Ovarian Reserve	FSH	LH	E2	AMH	
FBC	Normal	Abnormal			
U&E's	Normal	Abnormal			
LFT's	Normal	Abnormal			
Clotting Profile 1	Normal	Abnormal			
Karyotyping	Normal	Abnormal	Female Male		
Blood Group + Rhesus Factor					
Scan Summary	Normal	PCO	Anatomical Abnormality		
Vaginal Swabs	Normal	Abnormal	Type of Abnormality:		
IB Gen					
Semen Analysis	Normal	Abnormal	Type of Abnormality:		
DNA Fragmentation	Normal	Abnormal	Type of Abnormality:		

Transvaginal Scan details:

Uterus: **Position** **Size:** **Fibroids:**	**Anterverted** **Retroverted** **Axial** **Yes No Details**
Right Ovary:	

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Size: **Appearance:** **Antral Follicle Count**	
Left Ovary: **Size:** **Appearance:** **Antral Follicle Count:**	

Date: **Day of Cycle:**

Follow up plan

Date:

1. **Humira:** No Yes: x 2 or x 4
2. **Treatment Programme:** Normal Borderline High Complex Very High
3. **Hydroxychloroquine**
4. **No action**

Aspirin: 75mg 150mg	**Folic acid (mg):** 0.4 or 5mg	**Metformin (mg):** 500 or 1000 od /bd / tds / qds	**Cyclogest** 400mg od/ bd
Prednisolone (mg): 25mg or 40mg	**Omeprazole (mg):** 20mg od	**Thyroxine (mcg):** Dose:	**Hydroxychloroquine (mg):** 400
LMWH: OD or BD Fragmin 5000iu Clexane 40mg	**Intralipid Infusion** 4 or 5 times	**IVIG**	**Others**
Info Sheets given Yes or No	**Side Effects explained** Yes or No	**Consent given** Yes or No	**Patient made aware that the drugs are not licenced for use in pregnancy and we lack scientific evidence to show that the treatment works** Yes or No