REPRODUCTIVE IMMUNOLOGY CLINIC

Dr Gamal Matthias, MD, MBBS, FRCOG, FICS, FRANZCOG,CCST
Consultant Gynaecologist & Fertility, Reproductive Immunology

Patient's Name:
DOB:
Address:
Mobile phone: E Mail address:

HISTORY:

1. Recurrent first trimester miscarriage
   Details:

2. Second Trimester fetal loss
   Details:

3. Unexplained intra uterine fetal death
   Details:

4. Intra uterine fetal growth retardation (IUGR)
   Details:

5. Secondary Miscarriage/s
   (The couple has one or two live born children and then experience miscarriage/s)
   Details:

6. Recurrent IVF or assisted reproduction procedures failure.
   Details:

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7. Autoimmune Disorders
   eg. lupus, Rheumatoid Arthritis, Chron's disease, ulcerative colitis, skin rashes, hives, sore joints, etc.
   Details:

8. Thyroid Problems:
   (hyper or underactive thyroid or thyroiditis or thyroid antibodies)
   Details:

9. History of blood clotting problem
   (phlebitis or blood clots in arteries or veins)
   Details:

10. Endometriosis
    Details:

11. Family history of miscarriage, infertility or autoimmune disease
    Details:

12. Other relevant medical **obstetric** or **gynaecological** history
    Details:

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13. Patient's blood group ______

    Husband's blood group ______

14. Any other relevant information: ______

______

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TEST RESULTS:

Please attach copies or write below results of tests and investigations carried out previously:

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CURRENT MEDICATIONS :

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ALLERGIES :

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______

DR GAMAL MATTHIAS, MB, BS, FRCOG, FICS, FRANCOG, CCST
Consultant Obstetrician & Gynaecologist

NEW PATIENT DETAIL SHEET

WELCOME TO OUR GYNAECOLOGY & OBSTETRICS and REPRODUCTIVE IMMUNOLOGY CLINIC

Please complete the following information sheet and CIRCLE the appropriate number of supplied answers.

If you have any difficulty in completing the form, please ask us for help.

SURNAME: ______________________

FIRST NAME: ______________________

ADDRESS: ______________________

____

POSTCODE: __________

CONTACT NOS: (Home) ______________________

(Mobile) ______________________

E MAIL ADDRESS: ______________________

DATE OF BIRTH: ______________

OCCUPATION: ______________________

NAME OF HUSBAND OR NEXT OF KIN: ______________ Relationship: ____________

OCCUPATION: ______________ PHONE NO: ____________

REFERRING GP: ______________ PROVIDER NO: ____________

MEDICARE NO: ______________ EXPIRY DATE: ____________

COUNTRY OF BIRTH: ____________

ARE YOU A PENSIONER? YES / NO

DO YOU HAVE PRIVATE HOSPITAL INSURANCE? YES / NO

IF INSURED, NAME OF FUND: ______________________

MEMBERSHIP NO: ______________

By submitting this form I agree to Terms of Service, Privacy Policy stated on the clinic website and agree to a report to be issued to the referring doctor.