



Infertility Treatment
Endometriosis
Laparoscopic Surgery
Reproductive Microsurgery

Confidential Patient Information - Registration Form

PERSONAL DETAILS

Family Name: _____ First Name: _____
Maiden Name: _____ Date of Birth: _____
Occupation: _____
Mailing Address: _____
Suburb: _____ Postcode: _____
Mobile: _____ Email: _____
Medicare Number: _____ Ref No: _____ Exp Date: _____
Private Health Fund: _____ Membership Number: _____

PARTNER DETAILS (if applicable)

Family Name: _____ First Name: _____
Maiden Name: _____ Date of Birth: _____
Occupation: _____
Mailing Address: _____
Suburb: _____ Postcode: _____
Mobile: _____ Email: _____
Medicare Number: _____ Ref No: _____ Exp Date: _____
Private Health Fund: _____ Membership Number: _____

REFERRING DOCTOR

Name: _____
Address: _____

Other rooms

Suite 3, 252 Clayton Road
Clayton, Victoria, 3168

Level M, 233 Collins Street
Melbourne, Victoria, 3000

9 Hastings Street
Frankston, Victoria, 3199

Suite 8, 262 Main Street
Mornington, Victoria, 3931

8 Brettoneux Street
Seymour, Victoria, 3660



Privacy Statement

As a patient of Prof. Luk Rombauts, a medical record containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details.

During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation.

If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request.

Prof Luk Rombauts strongly promotes research to help develop better ways to diagnose and treat patients. If you do not wish to be contacted about research projects by researchers Prof Luk Rombauts collaborates with, please tick this box:

I hereby agree to the storage and the use of my medical information as outlined above.

Print Name: _____

Signature: _____

Date: _____

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Confidential Patient Information - Female

By answering the following questions as accurately as possible, you help us get a better understanding of the problems that may influence your fertility. Take your time and read all the questions carefully. Give the completed questionnaire to your doctor.

Family Name: _____ First Name: _____

Date of Birth: _____

Specific questions for the female partner:

Life style Weight (kg): _____ Height (cm): _____

Have you lost or gained a lot of weight recently? Yes No

Do you smoke? Yes No How many cigarettes per day? _____

Do you drink alcohol? Regularly Rarely Never

Do you come in contact with harmful substances in your work place: Yes No

Pregnancy Have you ever been pregnant? Yes No If yes, when was your last pregnancy? _____

If yes, specify how many pregnancies you have had in this table:

	Current Partner	Previous Partner(s)
Miscarriages		
Terminations of pregnancy		
Ectopic pregnancies (eg. in the tube)		
Live births		

If no, for how many months have you been trying to get pregnant? _____

Have you ever received infertility treatment? Yes No

• If yes, specify: _____

Have you ever used contraception? Yes No

• If yes, specify: Contraceptive pill Condoms Intrauterine device Other

How old were you when you had your first period? _____ years old.

How long is your cycle? (from the 1st day of your period until the 1st day of your next period): _____ to _____ days.

How many days does your period last? (from the 1st day until the last day of your period): _____

Is your period very painful? Yes No

Do you feel that the amount of blood loss is abnormal? Yes No

Do you have a lot of symptoms prior to your period? Yes No

Is there vaginal blood loss between your periods? Yes No

Other rooms



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Epworth Private Hospital
Suite 9.3, Level 9, 89 Bridge Road
Richmond, Victoria, 3121

Phone (03) 9516 2897
Fax (03) 9421 5932
Pager (03) 9387 1000
Email info@lukrombauts.com.au
Web www.lukrombauts.com.au
Provider 209245FW

Confidential Patient Information - Female

Is intercourse painful? Yes No Do you sometimes use a lubricant? Yes No

Do you sometimes notice semen leaking from the vagina after intercourse? Yes No

How often do you have intercourse per month? More than 8x 4-8x 1-4x Rarely

Have you ever had an operation? Yes No

- If yes, have you ever had a:
 - caesarean section: Yes No
 - operation on the cervix: Yes No
 - laparoscopy (telescope through belly-button): Yes No
 - gynaecological operation via abdominal incision: Yes No
 - operation on the bowel (such as appendectomy): Yes No

When did you have your last PAP smear? _____

Have you ever been treated for one of the following illnesses? diabetes: Yes No

thyroid disease: Yes No

tuberculosis: Yes No

Have you ever been hospitalised for an illness? Yes No

• If yes, specify: _____

Are you currently under any form of treatment? Yes No

• If yes, specify: _____

Do you have any diseases that run in the family? Yes No

Are you on regular medication and if yes which? _____

Do you have any allergies (medications, food ...)? _____

Has anyone in your family ever had a deep venous thrombosis (DVT)? Yes No

Has anyone in your family ever had a pulmonary embolus (blood clot in the lungs)? Yes No

Personal remarks: _____

I declare the above information to be complete and correct.

Signature: _____ Date: _____

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Confidential Patient Information - Male

By answering the following questions as accurately as possible, you help us get a better understanding of the problems that may influence your fertility. Take your time and read all the questions carefully. Give the completed questionnaire to your doctor.

Surname and given name: _____ First Name: _____

Specific questions for the male partner:

Life style Weight (kg): _____ Height (cm): _____
Have you lost or gained a lot of weight recently? Yes No
Do you smoke? Yes No How many cigarettes per day? _____
Do you drink alcohol? Regularly Rarely Never
Do you come in contact with harmful substances in your work place: Yes No

Have you ever been treated for one of the following illnesses?
diabetes: Yes No
thyroid disease: Yes No
liver or kidney disease: Yes No
chronic lung disease: Yes No

Do you know of people in your family who have an inherited condition? Yes No

Have you ever had an operation? Yes No

- If yes, have you ever had a:
operation on one or both testicles: Yes No
vasectomy: Yes No
operation on the bladder: Yes No
prostate operation: Yes No
operation on the penis: Yes No
inguinal hernia repair: Yes No
operation on your spinal cord: Yes No

Have you ever had mumps? Yes No At what age? _____

Have you ever experienced severe pain in one or both testicles? Yes No

Have you ever been treated for an undescended testicle? Yes No

Have you ever been treated for a urinary infection? Yes No

Have you ever had problems with erection or ejaculation? Yes No

If you have had other partners, was one of them ever pregnant? Yes No

Are you on regular medication and if yes which? _____

Do you have any allergies (medications, food ...)? _____

Personal remarks: _____

I declare the above information to be complete and correct.

Signature: _____ Date: _____

Other rooms