

Fertility Information Sheet

Please answer each question, for both partners wherever possible, with full details and dates. All information is strictly confidential.



Date of first consultation.....

How did you hear of this practice?
.....

Name (female) Name (male)

Address

..... Postcode

Email Address:

Phone No: (daytime) (....) (after hrs) (....).....(fax)

Mobile No (female) (male)

Age (female) Birth Time Birth Date Birth Place

Age (male).....Birth TimeBirth Date Birth Place

Please use 24 hour clock when giving birth time e.g. 3 minutes past midnight is 00:03am, 3.00pm is 15:00pm
If currently seeing a GP, gynaecologist, natural therapist or NFM practitioner give name & ph. No:
.....

Have you previously received a Natural Fertility Management Kit? **YES/NO** If so, from whom?

Was naturopathic advice included? **YES/NO**

Have you previously sent this practice any information/results? **YES/NO**

LIFESTYLE/ENVIRONMENT

What is your occupation? (please list specific activities):

(female)

(male)

Hobbies and other activities:

(female)

(male)

Do any of these activities involve contact with chemicals/heavy metals/other toxins?

(female) **YES/NO** give details:

(male) **YES/NO** give details:

Have you had any x/rays in the last 5 years (give approximate dates)?

(female) **YES/NO** (give details):

(male) **YES/NO** (give details):

How often do you fly? (female) (male)

Do you use a computer? If so, for how many hours daily?

(female)

(male)

	(female) YES/NO	(male) YES/NO
Do you regularly use a mobile phone?		
Do you sleep near a fuse box?		
Do you live/work near a transmitter/powerlines? (delete as appropriate)		
Do you have electrical appliances in your bedroom? Give details:		
Do you live/work near a major road/flight path? (Delete as appropriate)		
Do you use chemical cleansers or insecticides? Give details:		
Do you smoke cigarettes? If so, how many?		
Are you exposed to passive smoking?		
Do you use any recreational drugs (including alcohol)? Give details, including how often/amount:		
Have you recently conducted any renovations/pest control? Give details:		

Reproductive Health

Have you already started trying to conceive? **YES/NO** If so, when?:

Have you had any previous conceptions (female)? **YES/NO** Specify whether live birth, miscarriage, termination, premature, small for dates, prenatal death with dates and details of any complications and how long it took/any difficulties conceiving each one:

.....

Were these conceptions a result of your relationship with your current partner? **YES/NO**

Has your current partner been responsible for any conceptions other than those specified above? **YES/NO** Give details as above:

.....

FEMALES

Have you charted your basal (body at rest) temperature? **YES/NO** Give dates:

.....

Were you taking fertility drugs? **YES/NO**

Do you charts show a mid-cycle rise? **NEVER/SOMETIMES/USUALLY/ALWAYS**

On which day(s) of cycle (on average)

Have you charted you cervical mucus changes? **NEVER/SOMETIMES/USUALLY/ALWAYS**

Does it change mid-cycle? **NEVER/SOMETIMES/USUALLY/ALWAYS**

On which days do you experience fertile mucus?

Has your cervical mucus ever been tested? **YES/NO**

Results and dates:Amount pHferning (yes/no) Cervical Score

Have you previously had any of the following medical fertility investigations? (any further tests required can be recommended after consultation)

- a. Blood tests to show hormone levels **YES/NO** Give results (normal/elevated/deficient) of each hormone tested, dates & day of cycle: Were these tests done while you were taking fertility drugs? **YES/NO**
Oestrogen Progesterone LH
Prolactin Testosterone FSH
- b. Blood tests for thyroid function **YES/NO** Give results and dates (normal/elevated/deficient)
- c. Ultrasound **YES/NO** Give results and dates
- d. Laparoscopy **YES/NO** Give results and dates
Present condition of the left tube: **CLEAR/BOCKED/SCARRED/ADHERED**
Present condition of the right tube: **CLEAR/BOCKED/SCARRED/ADHERED**
Are there adhesions to any other part of the reproductive system? **YES/NO** Is there any evidence of endometriosis? **YES/NO**
Any other information
- e. Hysterosalpingogram **YES/NO** Give results and dates

Have you taken any fertility drugs? **YES/NO** Give details and dates

Have you undergone treatment on an assisted conception programme? **YES/NO** Give details and dates
.....
.....

Do you have any more treatment planned? **YES/NO** Give dates and details

Have you received any other form of treatment for reproductive problems? **YES/NO** Give details and dates
.....
.....

Have you, or do you, suffer from any of the following? If yes, give details and dates of treatment:

- a. Pelvic Inflammatory Disease **YES/NO**
- b. Endometriosis **YES/NO**
- c. Polycystic Ovarian Syndrome **YES/NO**
- d. Ovarian Cysts **YES/NO**
- e. Fibroids **YES/NO**
- f. Candida (Thrush) **NO/OCCASIONALLY/FREQUENTLY** If yes, is it vaginal or systemic?
How severe? What makes it worse?
How often have you suffered from candida in the last year?
- g. Genito-Urinary Infections or sexually transmitted diseases (including cystitis) **YES/NO**
Give details and dates
- h. Herpes/Blisters/Warts (delete as appropriate) **YES/NO** Give results and dates

Have you been tested for antibodies which can cause miscarriage? **YES/NO** Give results and dates
.....

Have you had a Cervical erosion/con biopsy/lazer treatment/cauterizations? **YES/NO** Give details and dates:
.....

Have you ever taken the contraceptive pill? **YES/NO** If yes, when? From to

Did you suffer any side effects? **YES/NO** Give details

Did you experience any delay in the return of your cycle? **YES/NO** Give details

Have you ever used an IUD? **YES/NO** If yes, when? From to

Did you experience any problems? **YES/NO** Give details:

Have you had any surgery in the pelvic/abdominal area? **YES/NO** Give details and dates:

How would you rate your libido? **STRONG/MODERATE/MILD**

MALES

Have you previously had any of the following medical fertility investigations? **YES/NO**:

- Semen analysis **YES/NO** Give details
 Count million/ml pH Volml
 Motility%..... Progressive motility% Motility index
 Are antibodies/clumping present? **YES/NO** Morphology (give % of normal sperm) TZI.....
- Blood tests for hormone levels **YES/NO** Give results 9normal/elevated/deficient) of each hormone tested and dates;
 Testosterone FSH LH
- Blood tests for thyroid function **YES/NO** give results, details and dates
- Have you been examined for a varicocele? **YES/NO** Give results, details and dates

Have you, or do you, suffer from any of the following: If yes, give details and dates of treatment:

- Undescended testes/testicular disease/vasectomy **YES/NO**
- Mumps (since puberty) **YES/NO**
- Gentio-urinary infections or sexually transmitted diseases **YES/NO**
- Herpes/Blisters/Warts (specify which) **YES/NO** Give details and dates

Have you received any other form of treatment of reproductive problems? **YES/NO** give details and dates

How would you rate your libido? **STRONG/MODERATE/MILD**

MUTUAL FERTILITY:

Have you and your current partner undergone a post-coital test? **YES/NO** Give results and dates

.....

Have you undergone a post-coital test with a different partner? **YES/NO** Give results and dates

.....

Have you and your current partner undergone a sperm/cervical mucus contact test? **YES/NO** Give results and dates (including cross-match with donor sperm/mucus)

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Have you been tested for sperm antibodies? **YES/NO** Give results and dates

.....

GENERAL HEALTH

Have you ever suffered from any of these conditions? (If yes, give details and dates):

a) Cardio-vascular disease (including abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations):

(female) **YES/NO**

(male) **YES/NO**

b) Liver disease (female) **YES/NO**

(male) **YES/NO**

c) Mental/Nervous system disease (female) **YES/NO**

(male) **YES/NO**

d) Glandular Fever/Chronic Fatigue (female) **YES/NO**

(male) **YES/NO**

e) Any other major disease (female) **YES/NO**

(male) **YES/NO**

Do you have regular (at least daily) bowel motions? (female) **YES/NO** (male) **YES/NO**

Do you use laxatives? (female) **YES/NO** Give details

(male) **YES/NO** Give details

Do you experience constipation, diarrhoea, flatulence, mucus or blood in stools, heartburn, indigestion, bloating or, bad breath?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Do you have any malabsorption or eating disorders?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Do you suffer from headaches?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Do you consider yourself stressed?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Do you sleep well?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Are you tired on waking?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

How do you rate your energy levels? (delete as appropriate): (female) **HIGH/MEDIUM/LOW**

(male) **HIGH/MEDIUM/LOW**

How often in the last year have you suffered from infections/colds/flu ect: (delete as appropriate):

(female) **NEVER/OCCASIONAL/FREQUENT** (male) **NEVER/OCCASIONAL/FREQUENT**

Do you have any allergies or sensitivities?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Do you suffer any of the following? *(please tick)*

	Female	Male		Female	Male		Female	Male
Arthritis			Dizziness			Mouth ulcers		
Asthma			Ear infections			nasal or sinus congestion		
Back pain			Food cravings			Numbness/tingling		
Bleeding gums			Forgetfulness			Palpitations		
Brittle nails			Hair loss			Panic attacks		
Bruising			Hayfever			Sensitivity to light/noise		
Cold hands/feet			Irritability			Sensitivity to odours		
Confusion			Irritable bowel			Skin problems/rashes		
Cramps			Itchiness			Sweating (excess) (night)		
Depression			Joint/muscle pain			Tinnitus		
Dermatitis/eczema			Migraine			Varicose veins		

Are you taking medication?

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Are you taking any dietary supplements? *(Please bring in all containers.)*

(female) **YES/NO** Give details

(male) **YES/NO** Give details

Who prescribed these supplements?

(female) (male)

CYCLE DETAILS

How often do you menstruate? Normal average length of cycle isdays.

If this varies, give shortest cycle usually experienced, days, and longest usually experienced days.

How many days do you bleed for? Is the flow **HEAVY/MEDIUM/LIGHT**? Is the blood **BRIGHT/DARK**?

Are there clots in the blood? **NEVER/OCCASIONALLY/USUALLY/ALWAYS**

How would you describe these clots: **SMALL & STRINGY/SMALL & LUMPY/LARGE & LUMPY**

Do you experience spotting before your period starts **YES/NO** If so, for how many days?

Do you experience mid-cycle spotting **YES/NO** Give details

Give the number of days, severity and timing if you suffer from the following menstrual symptoms:

	<i>None/Slight Moderate/Severe</i>	<i>Number of Days</i>	<i>Before/During Period</i>
Abdominal cramping/aching (specify which)			
Backache			
Nausea/Vomiting (specify which)			
Headaches			
Constipation/Diarrhoea (specify which)			
Skin problems			
Sore breasts			
Fluid retentions			
PMT			
Fatigue			
Food cravings			

If you experience food cravings, what are these for?

If you crave sugar, is this principally for chocolate?

Do you need to take pain killers? **NEVER/SOMETIMES/USUALLY/ALWAYS**

If so, for how many days before/during your period?

Have there been any recent changes in your cycle? **YES/NO** Give details

I recognise that by providing my practitioner with complete details of my health history, I am enabling them to regard all aspects of my health status in my treatment. By not disclosing vital information this may have an impact on the success of my treatment outcomes. All of my case details are confidential and will be treated as such by my practitioner. I understand that 24 hours notice is required for cancellation of appointments or a fee of \$30 will be charged.

Client: _____ Date: _____

Practitioner: _____ Date: _____