FERTILITY INFORMATION SHEET

Please answer each question for both partners wherever possible. All information is strictly confidential.

Date of first consultation …… How did you hear of this practice? ……..……

NAME (female/partner 1)…… NAME (male/partner 2) ……..……

ADDRESS ……..…Postcode ……..

Phone Nos: ……..…….……..…….

If currently seeing a GP, gynaecologist or natural therapist give name(s) and ph. No.(s) ……..…….…….

LIFESTYLE / ENVIRONMENT

What is your occupation (please list specific activities): (1) ……..……..

(2) ……..……

Hobbies and other activities: (1) ……..…… (2) ……..……...

Do any on these activities involve contact with chemicals / heavy metals / other toxins? (1) YES/NO give details

……..……(2) YES/NO give details ……..……

How often do you fly ? (1) ……..…….. (2) ……..……

Do you use a computer? If so, for how many hours daily? (1) ……..…… (2)……

	(1/female) YES/NO	(2/male) YES/NO
Have you had any X-rays in the last 3 years?		
Do you use cosmetics, hair spray/products, perfume or non organic skin care?		
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 regularly travel in peak hour/busy traffic? (delete as appropriate)		
Do you use chemical cleaners 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: (female) (male)		
Have you recently conducted any renovations / pest control? Give details:		

Are you taking any dietary / herbal supplements? (please bring in all containers for clarification of ingredients and dosages).

(female) YES/NO Give details ..……

(male) YES/NO Give details …….....

Who prescribed these supplements? (female) ……..……

(male) ……

MENSTRUAL CYCLE DETAILS

The average length of your cycle is …….. days (first day of period to first day of next period)

If this varies, give the shortest cycle usually experienced, ……… days, and the 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 / OCCASSIONALLY / USUALLY / ALWAYS

How would you describe these clots? SMALL (less than 10cent piece) LARGE (bigger than a 10 cent piece)

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 ……

Do you experience mid-cycle pain? YES/NO Give details ……..……..

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

	None / Slight Moderate / Severe	Number of Days	Before / During Period
Abdominal cramping/aching (specify which)			
Backache			
Nausea/Vomiting (specify which)			
Headaches			
Constipation/Diarrhoea (specify which)			
Skin problems			
Sore breasts			
Fluid retention			
Moodiness/Irritability/depressed (specify which)			
Fatigue			
Food cravings			
Sleep difficulties			
Energy changes			

If you experience food cravings, what are these for? …….

If you crave sugar, is it 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 ……..

ADDITIONAL INFORMATION (Please add a separate sheet if needed)

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 / perinatal 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 your charts show a mid-cycle rise? NEVER / SOMETIMES / USUALLY / ALWAYS On which day(s) of cycle (on average) …

Have you ever charted your cervical mucus changes? YES/NO

Do you look for cervical mucus changes? NEVER / SOMETIMES / USUALLY / ALWAYS

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

On which days do you experience fertile mucus?.....

Have you previously had any of the following medical fertility investigations?

a) Blood tests to show hormonal 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 …….
   Is there any evidence of endometriosis? YES/NO
   Is there any evidence of blocked fallopian tubes or adhesions? YES/NO

   Any other information ……..

e) Hysterosalpingogram YES/NO Give results and dates ……

f) Hysteroscopy 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 treatments planned? YES/NO Give dates and details …….

……...

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, how often have you suffered from it the last year? ……How severe? ……..

What makes it worse? ……..

g) Genito-Urinary Infections or sexually transmitted diseases (including cystitis) YES/NO Give details and dates ……...

h) Herpes/Warts (delete as appropriate) YES/NO ……..

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

Have you had a recent Pap Smear? YES/NO Give details and dates ……...

Have you had a Cervical erosion/cone biopsy/laser treatment/cauterization? 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?

a) Semen analysis YES/NO Give details and dates

Count ……million/ml pH …….. Volume …… ml Motility ……%

Morphology (give % of normal sperm) ……% TZI ……..

Is clumping present? YES/NO Have you been tested for sperm antibodies? YES/NO Give results and dates

……...

b) Blood tests for hormone levels YES/NO Give details and dates

Testosterone ……..…… FSH ……. LH……..…… Prolactin ……...

c) Blood tests for thyroid function YES/NO Give results and dates (normal / deficient / elevated)

d) 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:

a) Undescended testes/testicular disease/vasectomy YES/NO ……...

b) Mumps (since puberty) YES/NO ……...

c) Genito-urinary infections or sexually transmitted diseases YES/NO ……..

d) Herpes/Warts (specify which) YES/NO Give details and dates ……

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

……..

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

GENERAL HEALTH

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

a) Cardiovascular disease (including abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations) (1) YES/NO ……

(2) YES/NO ……..

b) Liver disease (1) YES/NO ……..

(2) YES/NO ……..……

c) Nervous system/mental/emotional disease (1) YES/NO ……...

(2) YES/NO ……..……

d) Glandular Fever/Chronic Fatigue (1) YES/NO ……

(2) YES/NO ……..……

e) Any other major disease/including auto-immune conditions (1) YES/NO ……..…

(2) YES/NO ……..……

f) Do you have regular (at least daily) bowel motions? (1) YES/NO (2) YES/NO

If not, on how many days in an average week? (1) ……..(2) ……..

Do you use laxatives? (1) YES/NO Give details ……

(2) YES/NO Give details ……..……...

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

(1) YES/NO Give details ……...

(2) YES/NO …… ……

h) Do you have any malabsorption/eating disorders? (1) YES/NO Give details ……..……

(2) YES/NO Give details ……..……...

i) Do you suffer from headaches? (1) YES/NO Give details ……

(2) YES/NO Give details ……..……...

j) Do you consider yourself stressed? (1) YES/NO Give details ……...

(2) YES/NO Give details ……...

k) Do you sleep well? (1) YES/NO Give details ……

(2) YES/NO Give details ……..……...

l) Are you tired on waking? (1) YES/NO Give details ……..

(2) YES/NO Give details ……..……...

m) How do you rate you energy levels? (1) HIGH/MEDIUM/LOW (2) HIGH/MEDIUM/LOW

n) How often in the last year have you suffered from infections/colds/flu etc?

(1) NEVER / OCCASIONALLY / FREQUENTLY (2) NEVER / OCCASIONALLY / FREQUENTLY

o) Do you have any allergies or sensitivities? (1) YES/NO Give details ……..

(2) YES/NO ……..……

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

	1 / female	2 / male		1 / female	2 / male		1 / female	2 / male
Arthritis			Ear infections			Mouth ulcers		
Asthma			Eczema			Numbness/tingling		
Back pain			Food cravings			Palpitations		
Bleeding gums			Forgetfulness			Pain attacks		
Brittle nails			Hair loss			Sensitivity to light/noise		
Bruising			Hay fever			Sensitivity to odours		
Cold hands/feet			Irritability			Sinus congestion		
Confusion			Irritable bowel			Skin problems/rashes		
Cramps			Itchiness			Sweating excess/night		
Depression			Joint/muscle pain			Tinnitus		
Dizziness			migraine			Varicose veins		

Are you taking medications, including the type and dose?

(1) YES/NO Give details ……..

(2) YES/NO Give details ……..