Natural Fertility Management

CONCEPTION PROGRAM QUESTIONNAIRE

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

DATE OF CONSULTATION _____

HOW DID YOU HEAR OF THIS PRACTICE? _____

FEMALE NAME _____

AGE _____ BIRTH DATE_____ BIRTH TIME _____ BIRTH PLACE _____

Please use 24 hour clock eg: 3.00pm is 15:00pm

OCCUPATION (please list specific activities) _____

_____

PHONE NO' WORK (___) _____ HOME (___)_____ MOB _____

ADDRESS _____

_____

EMAIL _____ FAX (___) _____

GENERAL PRACTITIONER _____

MALE/PARTNER NAME_____

AGE _____ BIRTH DATE_____ BIRTH TIME _____ BIRTH PLACE _____

Please use 24 hour clock eg: 3.00pm is 15:00pm

OCCUPATION (please list specific activities) _____

_____

PHONE NO' WORK (___) _____ HOME (___) _____ MOB _____

ADDRESS _____

_____

EMAIL _____ FAX (___) _____

GENERAL PRACTITIONER _____

IF CURRENTLY SEEING A GYNAECOLOGIST / SPECIALIST, NATURAL THERAPIST OR NFM PRACTITIONER

NAME _____

PHONE _____

OFFICE USE ONLY			
KIT	END OF PCHC	RESULT	END OF TREATMENT

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

Hobbies and other activities (please include gardening, sports activities, swimming (in a pool), crafts, etc.):

(Female) _____

(Male) _____

	Female YES/NO	**Male YES/NO**
In the past two years, have any of your activities involved frequent contact with chemicals including: manufacture or degrading of plastics; paints; new carpets; new car; refrigeration or air conditioning gases; glues; chemical cleansers or insecticides; frequent handling of carbonless copy paper; unfiltered water; pest control; hair chemicals such as colouring or perming agents? (please circle as appropriate). If yes, give details and dates: (female) _____ _____ (male) _____		
In the past two years have any of your activities involved contact with heavy metals? If yes, give details and dates: (female) _____ (male)		
Have you had any X-rays (including dental) in the past three years? If yes, give details and dates: (female) (male)		
Have you flown in the past three years? If yes, give details of frequency: (female) (male)		
Have you regularly used a mobile or cordless phone in the past two years or less?		
Do you use a computer? If yes, for how many hours per day? (female) _____ hrs (laptop/desktop/flat screen/CRT screen) (delete as appropriate) (male) hrs (laptop/desktop/flat screen/CRT screen) (delete as appropriate)		
Do you use a microwave oven? If yes, how often? (female) (male)		
Do you sleep near a fuse box? If yes, how long has this been the case? _____		
Do you live/work near a transmitter/power lines? (delete as appropriate)		
Do you have wireless technology at home or work? If yes, give details: (female) (male)		
Do you have electrical appliances in your bedroom? If yes, give details: _____		
Do you live/work near a main road/flight path? (delete as appropriate)		
Do you regularly travel in rush hour/busy traffic? (delete as appropriate)		
Do you use chemical cleansers or insecticides in your kitchen or bathroom? If yes, give details:		
Have you recently conducted any renovations and/or pest control? If yes, give details:		
Do you use non-toxic personal care products (eg toothpaste, cosmetics, antiperspirants)? If no, give details. If yes, provide brands: (female) _____ (male)		
Do you use any recreational drugs including alcohol? If yes, give details including type, amount and frequency. (female) _____ (male)		
Do you have any tattoos? If yes, please give details (number, when done, black or coloured). (female) (male)		
Do you have any body piercing? If yes, please give details (when done, location). (female) (male)		
Do you smoke cigarettes? If yes, what strength and how many per day/week? (female) (male)		
Have you stopped smoking cigarettes in the past four months? If yes, when? (female) (male)		
Are you exposed to passive smoking? If yes, how often? (female) (male)		
Do you drink coffee, caffeine containing drinks or tea? If yes, give details including what, how often and how much: (female) _____ (male)		
Do you wash your fruit and vegetables before eating them?		
Do you eat organic foods? If yes, what percentage of your food is organically grown/fed? (female) (male)		

REPRODUCTIVE HEALTH

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

Have you had any previous conceptions (female)? **YES / NO** (male)? **YES / NO**

Specify whether live birth/ miscarriage/ termination/ premature/ small for dates/ perinatal death/ stillbirth, 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 when charting your temperatures? **YES / NO**

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

On which day(s) of cycle (on average) does the temperature rise? _____

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

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

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

On which days do you experience fertile mucus? _____ Has your cervical mucus ever been tested? **YES / NO**

Give results and dates: Amount _____ pH _____ Ferning **(YES / NO**) Cervical Score _____

Have you previously had any of the following investigations? (Any further tests can be recommended after consultation).

a) Blood tests to show hormone levels **YES/NO** Were these tests done while you were taking fertility drugs? **YES/NO**

Give results (normal / elevated / deficient) of each hormone tested, dates & day of cycle:

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 left tube: **CLEAR / BLOCKED / SCARRED / ADHERED**

Present condition of right tube: **CLEAR / BLOCKED / 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** or Hy-Co-Sy **YES / NO** Give results and dates: _____

_____

Left tube: **CLEAR / BLOCKED / PARTIALLY BLOCKED**

Right tube: **CLEAR / BLOCKED / PARTIALLY BLOCKED**

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 details and dates: _____

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** _____

_____

h) Herpes/Blisters/Warts (delete as appropriate) **YES / NO** _____

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

_____

Have you had a recent Pap Smear? **YES / NO** Give results and dates: _____

Have you had a cervical erosion/cone biopsy/loop incision/laser 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 and dates: _____

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 results and dates for the following:

Concentration _____ million/ml pH _____ Vol _____ ml Vitality _____ %

Motility _____ % Rapid / Progressive motility _____ % Motility index _____

Clumping _____ % Morphology (% of normal sperm) _____ % TZI _____

Sperm antibodies _____ % Type _____ Blood/Semen Viscosity _____

DNA fragmentation SCSA / TUNEL _____% Grade _____ Highgreen _____% Grade _____

Was this semen analysis carried out at a laboratory associated with/specialising in infertility assessment? **YES / NO**

b) Blood tests for hormone levels **YES/NO** Give results (normal/elevated/deficient) of each hormone tested and dates:

Testosterone _____ FSH _____ LH _____ Prolactin _____

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

d) Physical or ultrasound varicocoele examination **YES/NO** Give results and dates: _____

Do you exercise wearing **TIGHT / SYNTHETIC SHORTS / WETSUITS**? (Please circle as appropriate) **YES / NO**

What style of underwear do you use? **BOXER / JOCKEY LOOSE / TIGHT FITTING SYNTHETIC / NATURAL FIBRE**

Do you use **SAUNAS / SPAS / HOT BATHS?** (please circle)**YES / NO**

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

a) Undescended testes/testicular disease or injury/vasectomy **YES / NO** _____

b) Mumps (since puberty/aged twelve) **YES/NO** _____

c) Genito-urinary infections or sexually transmitted diseases **YES/NO** _____

d) Herpes/Blisters/Warts (delete as appropriate) **YES/NO** _____

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**

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): _____

Have you **(female**) been tested for sperm antibodies? **YES / NO** Give results and dates: _____

_____

GENERAL HEALTH

Height (in cms) (female) _____ (male) _____ Weight (in kgs) (female) _____ (male) _____

Waist / hip (in cms) (female) _____/ _____ (male) _____ / _____

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

a) Cardio-vascular disease (eg 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, including auto-immune conditions

(female) **YES / NO** _____

(male) **YES / NO** _____

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

If not, on how many days in an average week? (female) _____ (male) _____

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/bad breath?

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

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

Do you have any malabsorption/eating disorders? (female) **YES / NO** Give details:_____

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

Do you experience food cravings? If so, is this for sugar / chocolate / carbohydrates?

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

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

Do you suffer from headaches or migraine? (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? (female) **HIGH / MEDIUM / LOW** (male) **HIGH / MEDIUM / LOW**

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

(female) **NEVER / OCCASIONALLY / FREQUENTLY** (male) **NEVER / OCCASIONALLY / FREQUENTLY**

Do you have any allergies or sensitivities? (please include salicylate allergy + hayfever)

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

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

Do you suffer (recently or to a significant degree) from any of the following? (please tick)

	Female	Male		Female	Male		Female	Male
Anxiety			Depression			Mouth ulcers		
Arthritis			Dermatitis/eczema			Nasal/sinus congestion		
Asthma			Dizziness			Numbness/tingling		
Back pain (lower)			Ear infections			Panic attacks		
Bleeding gums			Forgetfulness			Sensitivity to light/noise		
Brittle nails			Hair loss (not balding)			Sensitivity to odours		
Bruising			Irritability			Skin problems/rashes		
Cold hands/feet			Irritable bowel			Sweating (excess/night)		
Confusion			Itchiness			Tinnitus		
Cramps (not menstrual)			Joint/muscle pain			Varicose veins		

Do you do any exercise? Give details including frequency and length of time per week:

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

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

Are you taking medication? **(*Please bring in all containers to show ingredients and dosages).***

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

_____

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

_____

Are you taking any dietary supplements? **(*Please bring in all containers to show ingredients and dosages).***

(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 is _____ days (eg 27/28/29/30/31 etc).

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

Has it been more than 6 weeks since your last menstrual period? **YES/ NO** If so, how long? _____ weeks/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: _____

Do you experience mid-cycle pain? **YES / NO** Give details: _____

Do you use **CLOTH (REUSABLE) PADS / OTHER PADS / ORGANIC TAMPONS / OTHER TAMPONS**? (please circle)

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			
PMT			
Fatigue			
Food cravings (specify eg sugar/chocolate)			

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

If so, for how many days before/during your period? (Before _____ days / During _____ days)

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

_____

ADDITIONAL INFORMATION (Please add separate sheet if needed)