Natural Fertility Management

FEMALE PATIENT QUESTIONNAIRE

Please answer each question, with full details and dates. All information is strictly confidential.

DATE OF CONSULTATION ______________________________

HOW DID YOU HEAR OF THIS PRACTICE? ______________________________

____

NAME ______________________________

BIRTH DATE ______________________________ AGE ____________

OCCUPATION (please list specific activities) ______________________________

____

PHONE NO WORK (___) ____________ HOME (___) ____________ MOB ____________

ADDRESS ______________________________

____

EMAIL ______________________________ FAX (___) ____________

GENERAL PRACTITIONER ______________________________

IF CURRENTLY SEEING A SPECIALIST, NATURAL THERAPIST OR OTHER PRACTITIONER

(1) NAME ______________________________

(1) PHONE ______________________________

(2) NAME ______________________________

(2) PHONE ______________________________

(3) NAME ______________________________

(3) PHONE ______________________________

WHAT IS YOUR PRIMARY REASON FOR ATTENDING THE JOCELYN CENTRE? ____________

____

____

OFFICE USE ONLY			
	OTHER	RESULT	END OF TREATMENT

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GENERAL HEALTH

Height (in cms) ____________ Weight (in kgs) ____________ Waist / hip (in cms) ____________ / ____________

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

Liver disease **YES / NO** Details ______________________________

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

YES / NO Details ______________________________

Mental/ Nervous system disease **YES / NO** Details ______________________________

____

Glandular fever/ chronic fatigue **YES / NO** Details ______________________________

____

Other major diseases / conditions **YES / NO** Details ______________________________

____

Do you have any allergies or sensitivities? **YES / NO** Details ______________________________

____

Do you have any food cravings? **YES / NO** If so, is this for sugar / chocolate / carbohydrates?______________

____

How often in the last year have you suffered from infections/colds/flu etc.? **NEVER / OCCASIONALLY / FREQUENTLY**

Do you have regular (at least once daily) bowel motions? **YES / NO** Details ______________________________

____

If not, how often do you have a bowel motion in a typical week? ______________________________

Do you use laxatives? **YES / NO** Details ______________________________

Do you experience constipation / diarrhoea / flatulence / mucus or blood in stools / heartburn / indigestion / bloating / bad breath? **YES / NO** Details ______________________________

Do you have any malabsorption / eating disorders? **YES / NO** Details ______________________________

Do you suffer from headaches? **YES / NO** Details ______________________________

____

Do you consider yourself stressed? **YES / NO** Details ______________________________

____

Do you sleep well? **YES / NO** Details ______________________________

____

Are you tired on waking? **YES / NO** Details ______________________________

How do you rate your energy levels? **LOW / MEDIUM / HIGH**

Do you exercise regularly? **YES / NO** Details ______________________________

____

Do you smoke cigarettes? **YES / NO** Details ____________________

Do you use any recreational drugs (including alcohol?) **YES / NO** Details ____________________

____

Are you taking any medication? **YES / NO** (***Please bring in all containers to show ingredients and dosages)*** ______

____

____

Are you taking dietary supplements? **YES / NO** (***Please bring in all containers to show ingredients and dosages)*** _

____

____

____

____

REPRODUCTIVE HEALTH (IF APPROPRIATE)

Are you presently using any contraception / hormonally active drugs? **YES / NO** Details ____________________

Are you sexually active? **YES / NO**

Have you, or do you, suffer from any of the following? *(If yes, please provide dates and details of treatment)*

Pelvic Inflammatory Disease **YES / NO** ____________________

Endometriosis **YES / NO** ____________________

Ovarian cysts **YES / NO** ____________________

Polycystic Ovarian Syndrome **YES / NO** ____________________

Fibroids **YES / NO** ____________________

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? ____________________

Other genito-urinary infections or sexually transmitted diseases (including cystitis) **YES / NO** ____________________

____

Herpes / Blisters / Warts (specify which) **YES / NO** ____________________

Have you had a recent Pap Smear? **YES / NO** Dates and results ____________________

____

Cervical erosion / biopsy / laser treatment / cauterisation **YES / NO** ____________________

____

Have you had any conceptions? **YES / NO** Specify whether birth / miscarriage / termination with dates and details of any complications ____________________

____

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CYCLE DETAILS (IF APPROPRIATE)

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 cycle 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** Details ____

Do you experience mid-cycle pain? **YES/NO** 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? ____

Have there been any recent changes in your cycle? **YES / NO** Details ______________________________________

____

____

ADDITIONAL INFORMATION (Please add separate sheet if needed).

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