Natural Fertility Management

MALE 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

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)*** _

_____

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ADDITIONAL INFORMATION (Please use other side if needed).

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