Natural Fertility Management

PREGNANCY 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 (___) _____

GP/Obstetrician/Gynaecologist_____ PH:_____

If currently seeing a natural therapist or other practitioner:

(1) Name _____ Ph: _____

(2) Name _____ Ph: _____

(3) Name _____ Ph: _____

Are you currently enrolled at/in any hospital/prenatal program? **YES / NO** Details _____

_____

How many weeks into your pregnancy will you be at your first consultation? _____

Is this your first pregnancy? **YES / NO** Please provide details of any previous conceptions / births / miscarriages / terminations: _____

_____

_____

_____

OFFICE USE ONLY			
	OTHER	RESULT	END OF TREATMENT

LIFESTYLE/ENVIRONMENT

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

_____

Do any of your activities involve 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? **YES / NO** If yes, give details/dates:
Do any of your activities involve contact with heavy metals? **YES / NO** If yes, give details & dates:
Have you recently had any X-rays (including dental)? **YES / NO** If yes, give details & dates:
Have you recently flown and/or do you expect to fly during your pregnancy? **YES / NO** If yes, give details & dates:
Do you regularly use a mobile or cordless phone? **YES / NO** Do you carry it close to your body? **YES / NO**
Do you use a computer? **YES / NO** If yes, for how many hours per day? _____ hrs (laptop / desktop / flat screen / CRT screen) (delete as appropriate)
Do you use a microwave oven? **YES / NO** If yes, how often?
Do you sleep near a fuse box? **YES / NO**
Do you live/work near a transmitter/power lines? (delete as appropriate) **YES / NO**
Do you have wireless technology at home or work? **YES / NO** If yes, give details:
Do you have electrical appliances in your bedroom? **YES / NO** If yes, give details:
Do you live/work near a main road/flight path? (delete as appropriate) **YES / NO**
Do you regularly travel in rush hour/busy traffic? (delete as appropriate) **YES / NO**
Do you use chemical cleansers or insecticides in your kitchen or bathroom? **YES / NO** If yes, give details:
Have you recently conducted or are anticipating any renovations and/or pest control? (delete as appropriate) **YES / NO** If yes, give details:
Do you use non-toxic personal care products (eg toothpaste, cosmetics, antiperspirants)? **YES / NO** If no, give details. If yes, provide brands:
Do you use any recreational drugs including alcohol? **YES / NO** If yes, give details including type, amount and frequency:
Do you smoke cigarettes? **YES / NO** If yes, what strength and how many per day/week?
Are you exposed to passive smoking? **YES / NO** If yes, how often?
Do you drink coffee, caffeine containing drinks or tea? **YES / NO** If yes, give details including what, how often and how much:
Do you wash your fruit and vegetables before eating them? **YES / NO**
Do you eat organic foods? **YES / NO** If yes, what percentage of your food is organically grown/fed?

GENERAL HEALTH

Height (in cms) _____ Weight (in kgs) Now: _____ At start of pregnancy: _____

Have you ever suffered from any of the following 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 (pregnancy related or not) **YES / NO** Details _____

_____

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

_____

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

Do you have any food cravings? **YES / NO** If so, is it for sugar/chocolate/carbohydrates? Details _____

_____

Do you suffer from nausea/vomiting? **YES / NO** Details _____

_____

If so, does eating help to relieve your symptoms? **YES / NO** Details _____

_____

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 suffer from leg cramps / restless legs / swelling? **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 _____

_____

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)

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

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 during your pregnancy? _____

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

_____

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

Any atypical results on Pap Smears? **YES / NO** _____

_____

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

_____

Have you had any ante-natal tests? Ultrasound/Blood tests/Nuchal Translucency/CVS/Amniocentesis/Morphology Scan

Please provide dates & details: _____

_____

PLEASE PROVIDE ANY RELEVANT ADDITIONAL INFORMATION ON A SEPARATE SHEET. Thank you…