***Natural Fertility and Women’s Health***

***FERTILITY INFORMATION SHEET***

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of first consultation | | | | |
| Name (Female) | | Name (Male) | | |
| Address | | | | Postcode |
| Email Address | | | | |
| Phone Numbers | | | | |
| Daytime ( ) | | Afterhours ( ) | | |
| Mobile ( ) | | Fax ( ) | | |
| Age (Female) | Birthdate | | Birthplace | |
| Age (Male) | Birthdate | | Birthplace | |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

If currently seeing a GP, Gynaecologist, Natural Therapist or NF&WH Practitioner give name & Phone Number:

Was naturopathic advice included?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you previously sent this practice any information/results?

**Please bring with you any test/results that you have collected.**

***LIFESTYLE/ENVIRONMENT***

What is your current occupation? (Please list specific activities)  
(Female)   
(Male)

What work have you done in the past?  
(Female)   
(Male)

Hobbies and other activities? (Please include gardening, sports, swimming–in a pool, crafts, etc)  
(Female)   
(Male)

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.**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

In the past two years have any of your activities involved contact with heavy metals?  
If yes give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Have you had any X-rays (including dental) in the past three years? If yes give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Have you flown in the past three years? If yes give details of frequency.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Do you use a computer? If yes for how many hours per day?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female (laptop/desktop)**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male (laptop/desktop)**

If you regularly used a mobile phone do you keep it on your body?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Do you use a microwave oven? If yes, how often?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Do you sleep near a fuse box? If yes, how long has this been the case?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Do you live near a transmitter/powerlines? (delete as appropriate)

Do you have electrical appliances in your bedroom? If yes, give details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Do you live near a main road/flightpath? (delete as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

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.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you recently conducted any renovations and/or pest control?   
If yes, give details.

Do you use any recreational drugs including alcohol? If yes, give details on amount and frequency.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Do you smoke cigarettes? If yes, what strength and how many per day/week?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Have you stopped smoking cigarettes in the past four months? If yes, when?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Are you exposed to passive smoking? If yes, how often?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Do you drink coffee, caffeine containing drinks or tea? If yes, give details including what, how often and how much?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Do you wash you fruit and vegetables before eating them?

Do you eat organic foods? If yes, what percentage of your food is organically grown/fed?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

Do you have any concerns about exposure to chemicals or pollutants in your home or community? If yes, give details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Female**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Male**

***REPRODUCTIVE HEALTH***

***FAMILY HISTORY***

Is there any family history of health problems E.g. diabetes, cancer, auto-immune, infertility etc?

**Female**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mother | YES |  | NO |  |
| Father | YES |  | NO |  |
| Siblings | YES |  | NO |  |
| Paternal Grandparents | YES |  | NO |  |
| Maternal Grandparents | YES |  | NO |  |

**Male**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mother | YES |  | NO |  |
| Father | YES |  | NO |  |
| Siblings | YES |  | NO |  |
| Paternal Grandparents | YES |  | NO |  |
| Maternal Grandparents | YES |  | NO |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you already started trying to conceive?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

If so, have you had previous conceptions?

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 in conceiving each one?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Were these a result of your relationship with your current partner?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Has your current partner been responsible for conceptions other than those specified above? If yes, give details.

***FEMALES***

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you charted your basal (body at rest) temperature?  
Give Dates:

Were you taking fertility drugs?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you charted your cervical mucus changes?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Never** |  | **Sometimes** |  | **Usually** |  | **Always** |  |

Do you look for cervical mucus changes?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Never** |  | **Sometimes** |  | **Usually** |  | **Always** |  |

Does it change mid-cycle?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

On which day of your cycle do you experience fertile mucus?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you previously had any medical fertility investigations?  
(any further tests can be recommended after consultation)

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Oestrogen |  | Progesterone |  | LH |  |
| Prolactin |  | Testosterone |  | FSH |  |

**A.** Blood tests to show hormone levels  
Give results (normal/elevated/deficient) of each hormone tested, dates and day of cycle.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**B.**  Blood tests for thyroid function?

Give results and dates (normal/elevated/deficient)

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**C.** Ultrasound?   
Give results and dates:

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Clear |  | Blocked |  | Scarred |  | Adhered |  |

**D.** Laparoscopy?   
Give results and dates

Present condition of the left tube:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Clear |  | Blocked |  | Scarred |  | Adhered |  |

Present condition of the right tube:

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Are there adhesions to any other part of the reproductive system?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Is there any evidence of endometriosis?

Any other information?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Hystersalpinogram? If yes, give results and dates.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Clear |  | Blocked |  | Partially Blocked |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Clear |  | Blocked |  | Partially Blocked |  |

Left Tube:   
Right Tube:

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Hysteroscopy? If yes, give results and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Are you taking any fertility drugs? If yes, give dates and details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you undergone treatment on an assisted conception programme? If yes, give dates and details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

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

1. Pelvic Inflammatory Disease
2. Endometriosis
3. Polycystic Ovarian Syndrome
4. Ovarian Cysts
5. Fibroids

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **No** |  | **Occasionally** |  | **Frequently** |  |

1. Candida (Thrush)   
   If yes, is it vaginal or systemic?   
   How severe?

What makes it worse?   
How often have you suffered from Candida in the last year?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

1. Genito-Urinary Infections or sexually transmitted diseases (including cystitis/chlamydia) If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

1. Herpes/blisters/warts (specify which) If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you had a recent Pap smear? If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you had a cervical erosion/ cone biopsy, laser treatment, cauterisations? If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you ever taken the contraceptive pill/depo provera?  
When? From: To:

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Did you experience any delay in the return of your cycle? If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you ever used an IUD?  
When? From: To:  
Did you experience any problems? If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you had any surgery in the pelvic/abdominal area? If yes, give details and dates.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Strong** |  | **Moderate** |  | **Mild** |  |

How would you rate your libido?

***MALES***

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you previously had any medical fertility investigations?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

1. Semen analysis? If yes, give details and dates.

|  |  |
| --- | --- |
| **Count** | Million/mL |
| **pH** |  |
| **Vol** | mL |
| **Motility** | % |
| **Progressive Motility** | % |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Any antibodies/clumping present?

|  |
| --- |
| % |

Morphology (give % of normal sperm)?

1. Blood tests for hormone levels?  
   Give results (normal/elevated/deficient) of each hormone tested and dates

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Testosterone |  | FSH |  | LH |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

1. Blood tests thyroid function?  
   If yes, give results and dates (normal/elevated/deficient)

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

1. Have you been examined for varicocele? If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you received any form of treatment for reproductive problems? (such as undescended testes, testicular disease or vasectomy). If yes, give details and dates.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have you suffered from mumps? If yes, at what age?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Strong** |  | **Moderate** |  | **Mild** |  |

How would you rate your libido?

***MUTUAL FERTILITY***

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Have you been tested for sperm antibodies? If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

***GENERAL HEALTH***

Have you ever suffered from any of these conditions?   
Cardiovascular disease (including abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations? If yes, give details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Liver disease? (including gall bladder, hepatitis, fatty liver, raised liver enzymes). If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Mental/Nervous system disease? (depression, anxiety), If yes, give details.   
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Glandular Fever/Chronic Fatigue? If yes, give details.   
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you have regular (at least daily) bowel motions? If not how often in a typical week?   
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you use laxatives?   
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you experience constipation/diarrhea/flatulence/mucus or blood in stools/heartburn/ingestion/bloating or bad breath? If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you have a history of/or currently suffer from any digestive/eating disorder? If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you suffer from headaches? If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you consider yourself stressed? If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you sleep well? If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Are you tired on waking? If yes give details.  
Female  
Male

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **High** |  | **Medium** |  | **Low** |  |
| **High** |  | **Medium** |  | **Low** |  |

How do you rate your energy levels?  
Female  
Male

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Never** |  | **Occasionally** |  | **Frequently** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Never** |  | **Occasionally** |  | **Frequently** |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you have any allergies or sensitivities? (food or environmental). If yes, give details.  
Female  
Male

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

Do you have any other major diseases including auto-immune conditions?  
Female  
Male

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Arthritis |  | Asthma |  | Back Pain |  | Bleeding gums |  | Brittle nails |  | Cold hands/feet |  |
| Depression |  | Dizziness |  | Ear infections |  | Food cravings |  | Forgetfulness |  | Hair loss |  |
| Hay fever |  | Irritability |  | Irritable bowel |  | Itchiness |  | Joint pain |  | Migraine |  |
| Mouth ulcers |  | Numbness |  | Palpitations |  | Nasal/sinus congestion |  | Panic attacks |  | Odour sensitivity |  |
| Sweating (excess)(night) |  | Tinnitus |  | Varicose veins |  | Light/noise sensitivity |  | Skin problems, rashes, eczema |  |

Do you suffer from any of the following (Indicate if male or female suffers)?

Are you taking any medication? (prescribed or over the counter). If yes, give details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

**Female**

**Male**

Are you taking any dietary supplements or herbal/homeopathic medicines? If yes, give details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |
| **YES** |  | **NO** |  |

**Female**

**Male**

***CYCLE DETAILS***

How often do you menstruate?

Normal average length of cycle is days

If this varies, give shortest cycle usually expected: days, and longest: days

How many days do you bleed for? Days

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heavy |  | Medium |  | Light |  |

Is the flow?

How many times a day would you change a tampon/pad on a heavy day?

|  |  |  |  |
| --- | --- | --- | --- |
| **Bright** |  | **Dark** |  |

Is the blood:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Never** |  | **Occasionally** |  | **Usually** |  | **Always** |  |

Are there clots on the blood?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Small & Stringy** |  | **Small & lumpy** |  | **Large & lumpy** |  |

How would you describe these clots?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Do you experience spotting before your period starts? If so for how many days?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Do you experience flooding? If yes, give details.

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Do you experience mid-cycle spotting? If yes, give details.

Do you experience mid-cycle pain? If yes, give details.

Give the number of *Days, Severity and Timing* if you suffer from the following menstrual symptoms:

Abdominal cramping

Backache

Nausea/vomiting

Headaches

Constipation/diarrhoea

Skin problems

Sore breasts

Fluid retention

Emotional

Fatigue

Food cravings

If you experience food cravings, what are these for?

If you crave sugar, is this principally for chocolate?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Never** |  | **Occasionally** |  | **Usually** |  | **Always** |  |

Do you need to take pain killers?

For how many days before/during your period?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

Have there been any recent changes in your cycle? If yes, give details.

ADDITIONAL INFORMATION

(Please add separate sheet if required)