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FERTILITY JOURNAL

Name:

Address:

Date of Birth :

Email :

Mobile:

Occupation :

Height _____ Weight _____

General Health History :

Childhood health

Glandular fever
Mumps
Auto-immune diseases

Allergies

Hospitilisations

Operations

Current medications

Current supplements

Nutrition Profile

How much of your food comes from Organic origin ? _____%

Breakfast : _____

MT : _____

Lunch :_____

AT :_____

Dinner : _____

Snacks : _____

Beverages : _____

Alcohol per night : _____

Smoking _____

Bowel function :

Daily YES / NO if no how often : _____

Constipation _____

Diarrohea _____

Urination :

Easy YES / NO Night-time YES / NO how often ? _____

Infection history _____

Sleep : Hours per night : _____

Quality ? 1- 10 _____

Wake refreshed YES / NO

Dream life YES / NO

Systems Check

How regularly do you suffer from :

Headaches _____ daily weekly occasionally

Anxiety _____daily weekly occasionally

Colds and Flus _____ how many in the last year ? _____

Nausea _____

Mental Health history

Anxiety _____

Depression _____

Other _____

_____

Medication required_____

Treating doctor_____

Happiness / Contentment Scale

Generally you have feel in the past 12 months :

EXTREMELY CONTENT ON ALL LEVELS / ALWAYS HAPPY AND JOYFUL / OFTEN FEELING GOOD / OCASSIONALLY FEELING JOY / SELDOM HAPPY / MOSTLY DOWN / OFTEN TEARY AND OVERWHELMED / EXTREMELY MISERABLE

STRESS SCALE

LOW 1 2 3 4 5 6 7 8 9 10 HIGH

ENVIRONMENTAL HAZARDS ASSESSMENT

In the past 2 years have you had any exposure to :

(please circle)

Paints

Glues

Air- Con gases

New carpets

Pest control

Hair chemicals (colours or perms)

Insecticides for home use

Heavy metals

X-rays

Air flight how often, how long _____

Use of mobile phones and cordless phones

Computer use hours per week _____

Microwave oven use

Bed near fuse box

Work / live near power lines

Tattoos

Recreational drug use

Cigarette use

Menstrual Cycle first day of bleeding this cycle _____/_____/_____

Length _____ longest ever _____ shortest ever _____

Bleed pattern : Heavy days _____ Medium days _____ Light days _____

Clots YES / NO

Ovulation awareness YES / NO what day of your cycle do you think you ovulate? _____

Cervical mucous change awareness YES / NO

Mid –cycle pain? YES / NO

Mid-cycle spotting? Describe _____

Do you use : (circle)

Pads
Pads organic cotton
Tampons
Organic Tampons
Moon cup
Other

Problem areas / diseases :

History of :

Endometriosis YES / NO

_____

Polycystic ovarian Syndrome (PCOS) YES / NO

_____

Uterine Fibroids YES / NO

_____

Vaginal Candida infection YES / NO

_____

How often have you suffered from Candida in the past 6 months? _____

Herpes YES / NO

_____

How often have you suffered from Herpes in the last 6 months ? _____

Abnormal PAP smear result YES / NO

_____

Last PAP smear was taken _____

Cervical erosion, Cone Biopsy, Laser treatment, cauterizations ? YES / NO

_____

Pelvic Inflammatory disease YES / NO

_____

Cause ? _____

CONTRACEPTION :

Most recent use :
_____

Side effects
_____

Please list your type, duration of use and side-effects from past use :
_____

_____

_____

_____

Libido

How would you rate your libido? STRONG / MODERATE / MILD / NOT INTERESTED

DIAGNOSTIC PROCEDURES

Have you previously has any of the following investigations?

Hormonal blood tests YES / NO

Result :

Thyroid function blood tests YES / NO

Result :

Abdominal ultrasound YES / NO

Results :

Laparoscopy YES / NO

Present condition Left tube : CLEAR / BLOCKED / SCARRED / ADHERED

Present condition Right tube : CLEAR / BLOCKED / SCARRED / ADHERED

Any adhesions anywhere else?

Hysterosalpingogram YES / NO

FERTILITY TREATMENT

Have you had any of the following – please list when, outcome, side-effects if any

Fertility drugs : _____

IVF :_____

ICSI _____

Frozen embryo transfer : _____

Do you have any more treatments planned ? YES / NO when ? _____

Have you been using acupuncture YES / NO when ? _____

Other details : _____

_____

_____

_____

_____

_____