Cath Minter
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Fertility Treatement : Patient JOURNAL MALE

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 ?________________%

Week to week meal choices for each part of your day include:

Breakfast :

Morning Tea :

Lunch:

Afternoon Tea :

Dinner :

Beverages :

Smoking :

<u>Bowel function :</u>

Daily YES / NO if no how often : ___________________

Constipation ____________________________________

Diarrohea ______________________________________

<u>Urination :</u>

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

Infection history ____

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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

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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

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<u>Problem areas : Diseases</u>

Undescended testes YES / NO

Testes injury YES / NO details

____

Erectile dysfunction YES / NO

Sexual performance anxiety YES / NO

Mumps YES / NO

Urinary infections YES / NO

STD's YES / NO list specifically :

Any other problems or treatment ? Outline here :

<u>General</u>

What style of underwear do you use ? BOXERS / JOCKEY LOOSE / TIGHT

NATURAL FIBRE / SYNTHETIC

Do you exercise using wetsuits, cycling shorts, synthetic tight shorts? YES / NO

How often ? ______________________________

Do you use the SAUNA YES / NO how often? ______________________________________

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

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DIAGNOSTIC PROCEDURES

Semen analysis : YES / NO

Results : Concerntration ______________million/ml pH ________________________________

Motility ________________________% motility index ________________________________

Clumping YES / NO Morphology _________________________________

Sperm antibodies present YES / NO

Specialist infertility lab which performed the analysis YES / NO

Hormonal blood tests YES / NO

Thyroid function blood test YES / NO

Testes examination

By doctor : YES / NO when ____

Ultrasound YES / NO result ____