PERTH HEALTH & FERTILITY

Conception Programme Questionnaire

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

Date of first consultation…….. How did you hear of this practice? .....

NAME (female) …… NAME (male) ……

ADDRESS……

…… Post code…… Email ……

Phone No(s): (daytime) female:……..male:…….. (after hours) ……...

Age (female) ……...…Birth Date…..……Age (male)..……Birth Date……

Medications: female ……..male ……

Allergies: female: …… male: ……..

Medical conditions: female……male:……

LIFESTYLE / ENVIRONMENT

What is your occupation?
Female……..

Male……

Hobbies and other activities (please include gardening, sport activities, swimming (in a pool), crafts etc)
Female……..

Male……

	Female yes/no	Male yes/no
In the past two years have any of your activities involved frequent contact with chemicals including: manufacture of degrading of plastics; paints; new carpets; new car; refrigeration or air conditioning gases; glues; chemical cleansers or insecticides; unfiltered water; pest control; hair chemicals such as hair colouring If yes, give details and dates: Female:…….. Male:……		
In the past two years have any of your activities involved contact with heavy metals? If yes, give details and dates: Female…… Male……		
Have you had any X-rays (including dental) in the past three years? If yes, give details and dates: Female…… Male……		
Have you flown in the past three years? If yes, give details and dates: Female…… Male……		
Do you use a computer? If yes, for how many hours per day? Female……hrs (laptop/desktop) Male……hrs (laptop/desktop)		
Do you use a microwave oven? If yes, how often? Female…… Male……		

Do you sleep near a fuse box? If yes, how long has this been the case? Female…… Male……		
Do you live/work near a transmitter/powerlines? (delete as appropriate)		
Do you have wireless technology at home or work? If yes, give details: Female…… Male……		
Do you have electrical appliances in your bedroom? If yes, give details and dates: Female…… Male……		
Do you live/work near a main road/flight path? (delete as appropriate)		
Do you regularly travel in rush hour/busy traffic? (delete as appropriate)		
Do you use chemical cleansers or insecticides in your kitchen/bathroom? If yes, give details: ……		
Have you recently conducted any renovations and/or pest control? If yes, give details and dates:……		
Do you use non-toxic personal care products (e.g. toothpaste, cosmetics, antiperspirants). If no, give details, if yes, provide brands. Female…… Male……		
Do you use any recreational drugs including alcohol? If yes, give details including Type, amount and frequency? Female…… Male……		
Do you smoke cigarettes? If yes, what strength, and how many per day/week?: Female…… Male……		
Have you stopped smoking cigarettes in the past four months? If yes, when? Female…… Male……		
Are you exposed to passive smoking? If yes, how often? Female…… Male……		
Do you drink coffee, caffeine containing drinks or tea? If yes, give details including what, how often and how much? Female…… Male……		
Do you wash your fruit and vegetables before eating them?		
Do you eat organic foods? If yes, what percentage of your food is organically grown/fed? Female…… Male……		
Have you regularly used a mobile or cordless phone in the past two years or less?		

REPRODUCTIVE HEALTH

Have you already started trying to conceive? **YES/NO** If so, when? ……

Have you had any previous conceptions? Female? **YES/NO** Male? **YES/NO**

Specify whether live birth/miscarriage/termination/premature/small for dates/perinatal death/stillbirth, with dates or details of any complications and how long it took/any difficulties conceiving each one:……
……

Were these conceptions a result of your relationship with your current partner? **YES/NO**

Has your current partner been responsible for any conceptions other than those specified above? **YES/NO**

Give details as above:
……

FEMALES

Have you charted your basal (body at rest) temperature? **YES/NO**
Give dates:……

Were you taking fertility drugs when charting your temperature? **YES/NO**

Do your charts show a mid-cycle rise? **NEVER/SOMETIMES/USUALLY/ALWAYS**

On which day(s) of your cycle (on average) does the temperature rise? .....

Have you charted your cervical mucus changes? **YES/NO**

Do you look for cervical mucus changes? **NEVER/SOMETIMES/USUALLY/ALWAYS**

Does your mucus change mid-cycle? **NEVER/SOMETIMES/USUALLY/ALWAYS**

On which days do you experience fertile mucus?.....……

Has your cervical mucus ever been tested **YES/NO**
Give results and dates: Amount…… pH…… Ferning **(YES/NO)** Cervical score……..…

Have you previously had any of the following medical fertility investigations?

a) Blood tests to show hormone levels **(YES/NO)**
were these tests done while you were taking fertility drugs? **(YES/NO)**

Give results of each hormone tested, dates and day of cycle:

Oestrogen…….. Progesterone…..……LH……..……....

Prolactin…….....Testosterone…..……FSH……..……....

b) Blood tests for thyroid function **(YES/NO)**
Give results and dates (normal/elevated/deficient) ……

c) Ultrasound **(YES/NO)** Give results and dates……

d) Laparoscopy **(YES/NO)** Give results and dates……

Present condition of left tube: **(CLEAR/BLOCKED/PARTIALLY BLOCKED)**
Present condition of right tube: **(CLEAR/BLOCKED/PARTIALLY BLOCKED)**

Are there adhesions to any other part of the reproductive system? **(YES/NO)**
Is there any evidence of endometriosis? **(YES/NO)**

Any other information……..

e) Hysterosalpingogram **(YES/NO)** or Hy-Co-Sy **(YES/NO)**
Give results and dates……..……
……

Left Tube: **(CLEAR/BLOCKED/PARTIALLY BLOCKED)**
Right Tube: **(CLEAR/BLOCKED/PARTIALLY BLOCKED)**

f) Hysteroscopy **(YES/NO)** Give results and dates…….

Have you taken any fertility drugs? **(YES/NO)** Give details and dates……..

Have you undergone treatment on an assisted conception programme? **(YES/NO)**
Give details and
dates…….....

Do you have any more treatments planned? **(YES/NO)** Give details and
dates…...……..

Have you received any other form of treatment for reproductive problems? **(YES/NO)** Give details and dates……..

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

a) Pelvic Inflammatory Disease
(YES/NO)…….....

b) Endometriosis
(YES/NO)…….....

c) Polycystic Ovarian Syndrome
(YES/NO)…….....

d) Ovarian Cysts
(YES/NO)…….....

e) Fibroids
(YES/NO)…….....

f) Candida (Thrush) **NO/OCCASIONALLY/FREQUENTLY** Is it vaginal or systemic?.....……

How severe?..... What makes it worse?.....

How often have you suffered from candida in the last year?.....

g) Genito-Urinary Infections or sexually transmitted diseases (including cystitis) **(YES/NO)**……

……

h) Herpes/blisters/warts (delete as appropriate) **(YES/NO)** ……

Have you been tested for antibodies which can cause miscarriage? **(YES/NO)**
Give results and dates……...……...

Have you had a recent Pap Smear? **(YES/NO)** Give results and dates……

Have you had a cervical erosion/cone biopsy/loop incision/laser treatment/cauterizations? **(YES/NO)**
Give details and dates……

Have you ever taken the contraceptive pill? **(YES/NO)** If yes, when? From…… To……..

Did you suffer any side effects? **(YES/NO)** Give details……

Did you experience any delay in the return of your cycle? **(YES/NO)** Give details……..

Have you ever used an IUD? **(YES/NO)** If yes, when? From…….. To…….

Did you experience any problems? **(YES/NO)** Give details and dates……

Have you had any surgery in the pelvic/abdominal area? **(YES/NO)**
Give details and dates……

How would you rate your libido? **STRONG/MODERATE/MILD**

MALES

Have you previously had any of the following medical fertility investigations?

a) Semen analysis **(YES/NO)** Give results and dates for the following:

Count/Concentration……..……million/ml pH……..…… Ejaculate volume……ml

Motility……..% Rapid/progressive motility……..% Total morphology…….%

Is clumping present? **(YES/NO)** DNA fragmentation……..%

Have you been tested for sperm antibodies? **(YES/NO)** Give results and dates:
BLOOD/SEMEN……

Was this semen analysis carried out a laboratory associated with/specialising in infertility assessment?
(YES/NO)

b) Blood tests for hormone levels **(YES/NO)** Give results of each hormone tested. Date of test: ……....

Testosterone……. FSH……..…….LH……..……Prolactin……..

c) Blood tests for thyroid function **(YES/NO)** TSH:…….. T4……. T3……

d) Physical or ultrasound varicocoele examination **(YES/NO)** Give dates and results

……

Do you exercise wearing **TIGHT/SYNTHETIC SHORTS/WETSUITS** (please circle as appropriate)
(YES/NO)

What style of underwear do you use? **(BOXER/JOCKEY)** **(LOOSE/TIGHT FITTING)**
(SYNTHETIC/NATURAL FIBRE)

Do you use **SAUNAS/SPAS/HOT BATHS** (please circle) **(YES/NO)**

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

a) Undescended testes/testicular disease or injury/vasectomy **(YES/NO)**

……

b) Mumps (since puberty/aged twelve) **(YES/NO)**……..……..

c) Genito-urinary infections or sexually transmitted diseases **(YES/NO)**……..

d) Herpes/blisters/warts (delete as appropriate) **(YES/NO**)……..

Have you received any other form of treatment for reproductive problems? **(YES/NO)** Give details and dates: ……

How would you rate your libido? **STRONG/MODERATE/MILD**

MUTUAL FERTILITY

Have you and your current partner undergone a post-coital test? **(YES/NO)** Give results and dates: …….....

Have you undergone a post-coital test with a different partner? **(YES/NO)** Give results and dates: …….....

Have you and your current partner undergone a sperm/cervical mucus contact test? **(YES/NO)** Give results and dates (including cross-match with donor sperm/mucus): …….....
……

Have you (**female**) been tested for sperm antibodies? **(YES/NO)** Give results and dates:
……

GENERAL HEALTH

Have you ever suffered from any of these conditions? (If yes, give results and dates)

a) Cardio-vascular disease (abnormal blood pressure/high cholesterol/poor circulation/angina/palpitations)

(female) **YES/NO**……..

(male) **YES/NO**……

b) Liver disease (female) **YES/NO**……

(male) **YES/NO**……

c) Mental/Nervous system disease (female) **YES/NO**……..……..

(male) **YES/NO**……

d) Glandular Fever/Chronic fatigue (female) **YES/NO**……

(male) **YES/NO**……

e) Any other major disease, including auto-immune conditions

(female) **YES/NO**……..

(male) **YES/NO**……

Do you have regular (at least daily) bowel motions? (female) **YES/NO** (male) **YES/NO**

If not, on how many days in an average week? female) **……..** (male) **……..**

Do you use laxatives? (female) **YES/NO** Give details…….. (male) **YES/NO** Give details……

Do you experience constipation/diarrhoea/flatulence/mucus or blood in stools/heart burn/bloating/bad breath?
(female) **YES/NO** Give details……

(male) **YES/NO** Give details……...

Do you have any malabsorption/eating disorders? (female) **YES/NO** Give details……..

(male) **YES/NO** Give details……

Do you experience food cravings? If so, what for and if for sugar, is this principally chocolate?

(female) **YES/NO** Give details……

(male) **YES/NO** Give details……...

Do you suffer from headaches or migraine? (female) **YES/NO** Give details……

(male) **YES/NO** Give details……

Do you consider yourself stressed? (female) **YES/NO** Give details……

(male) **YES/NO** Give details……

Do you sleep well? (female) **YES/NO** Give details……

(male) **YES/NO** Give details……

Are you tired on waking? (female) **YES/NO** Give details……

(male) **YES/NO** Give details……

How do you rate your energy levels? (female) **HIGH/MEDIUM/LOW** (male) **HIGH/MEDIUM/LOW**

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

(female) **NEVER/OCCASIONALLY/FREQUENTLY** (male) **NEVER/OCCASIONALLY/FREQUENTLY**

Do you have any allergies or sensitivities? (please include salicylate allergy & hayfever)

(female) **YES/NO** Give details……

(male) **YES/NO** Give details……...

Do you suffer (recently or to a significant degree) from any of the following? (please tick)

	Female	**Male**		**Female**	**Male**		**Female**	**Male**
Anxiety			Depression			Mouth ulcers		
Arthritis			Dermatitis/eczema			Nasal/sinus congestion		
Asthma			Dizziness			Numbness/tingling		
Back pain (lower)			Ear infections			Panic attacks		
Bleeding gums			Forgetfulness			Sensitivity to light/noise		
Brittle nails			Hair loss (not balding)			Sensitivity to odours		
Bruising			Irritability			Skin problems/rashes		
Cold hands/feet			Irritable bowel			Sweating (excess/night		
Confusion			Itchiness			Tinnitus		
Cramps *not menstrual			Joint/muscle pain			Varicose veins		

Do you do any exercise? Give details including frequency and length of time per week:

(female) **YES/NO** ……

(male) **YES/NO** ……

Are you taking medication ***(please bring in ALL containers to show ingredients and dosages.)***

(female) **YES/NO** Give details

……

……

……

(male) **YES/NO** Give details

……

……

……

Are you taking any dietary supplements? ***(please bring in ALL containers to show ingredients & dosages.)***

(female) **YES/NO** Give details

……

……

……

……

……

……

(male) **YES/NO** Give details
……..
.....
.....
.....
.....
.....

Who prescribed these supplements? (female) ……... (male) ……..……

CYCLE DETAILS

How often do you menstruate? Normal average length of cycle is…….(e.g. 27/28/29/30/31)

If this varies, give shortest cycle usually experienced, …..……days, and the longest usually experienced, ……..…….. days.

Has it been more than 6 weeks since your last menstrual period? **YES/NO** If so, how long? …..weeks/days

How many days do you bleed for?..... Is the flow **HEAVY/MEDIUM/LIGHT?**

Is the blood **BRIGHT/DARK?** Are there clots in the blood? **NEVER/OCCASIONALLY /ALWAYS**

How would you describe these clots? **SMALL & STRING/SMALL & LUMPY/LARGE & LUMPY**

Do you experience spotting before your period starts? **YES/NO** If so, for how many days? …….

Do you experience mid-cycle spotting? **YES/NO** Give details:…….

Do you experience mid-cycle pain? **YES/NO** Give details:…….

Do you use **a menstrual cup/ pads/organic tampons/other tampons?**

Give the number of days, severity and timing if you suffer from the following menstrual symptoms.

	None/Slight/ Moderate/Severe	**Number of Days**	**Before/during Period**
Abdominal cramping/aching (specify which)			
Backache			
Nausea/vomiting (specify which)			
Headaches			
Constipation/diarrhoea (specify which)			
Skin problems			
Sore breasts			
Fluid retention			
PMT			
Fatigue			
Food cravings			

Do you need to take pain killers? **NEVER/SOMETIMES/USUALLY/ALWAYS**

If so, for how many days before/during your period? (Before……..…days/During……..…..days)

Have there been any recent changes in your cycle? **YES/NO** Give details:……

ADDITIONAL INFORMATION

(Please add separate sheet if needed)