**Conception Program Questionnaire**

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| **Date of First Consultation** |  |
| **Referred by** |  |
| **Address** |  |

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|  | **Female Details** | **Male Details** |
| **Full Name** |  |  |
| **DOB and Age** |  |  |
| **Daytime Phone** |  |  |
| **After-Hours Phone** |  |  |
| **Email** |  |  |
| **Allergies** |  |  |
| **Medical Conditions** |  |  |
| **Occupation** |  |  |
| **Medications\*** |  |  |
| **Supplements (and who prescribed them)** |  |  |
| **Please bring in ALL medication and supplement containers to your appointment to show ingredients and dosages.** |

**Lifestyle and Environment**

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| **Hobbies and other activities (please include gardening, sports activities, swimming in a pool, crafts etc):** |
| **Female** |  |
| **Male** |  |

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|  | **Female** **(yes/no, plus details)** | **Male** **(yes/no, plus details)** |
| In the past two years have any of your activities involved frequent contact with chemicals including: manufacture of plastics; paints; new carpets; new car; glues; chemical cleansers or insecticides; pest control; hair chemicals such as hair colouring etc.  |  |  |
| In the past two years have any of your activities involved contact with heavy metals? |  |  |
| Have you had any X-rays (inc. dental) in the past three years? If yes, give details/dates: |  |  |
| Have you flown in the past three years? If yes, give details and dates: |  |  |
| Do you use a computer (laptop/desktop)? If yes, for how many hours per day? |  |  |
| Do you use a microwave oven? If yes, how often? |  |  |
| Do you sleep near a fuse box?If yes, how long has this been the case? |  |  |
| Do you live/work near a transmitter or powerlines?  |  |  |
| Do you have electrical appliances in your bedroom? If yes, give details and dates: |  |  |
| Do you live/work near a main road/flight path? |  |  |
| 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/dates: |  |  |
| Do you use non-toxic personal care products (e.g. toothpaste, cosmetics, antiperspirants)? If no, give details. If yes, provide brands: |  |  |
| Do you use any recreational drugs including alcohol? If yes, give details including type, amount and frequency: |  |  |
| Do you smoke cigarettes? If yes, what strength, and how many per day/week? |  |  |
| Have you stopped smoking cigarettes in the past four months? If yes, when? |  |  |
| Are you exposed to passive smoking? If yes, how often? |  |  |
| Do you drink coffee, caffeine-containing drinks or tea? If yes, give details, including what, how often and how much: |  |  |
| 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: |  |  |
| Have you regularly used a mobile or cordless phone in the past two years or less? |  |  |

**REPRODUCTIVE HEALTH**

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| **Have you already started trying to conceive? Yes/no and 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, how long it took to conceive and any difficulties conceiving for each pregnancy:** |
|  |
| **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 and give details:**  |
|  |
| **Have you and your partner undergone a post-coital test? If yes, give results and dates.** |
|  |
| **Have you (female) been tested for sperm antibodies? If yes, give results and dates:** |
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**MALES**

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

1. **Semen Analysis: If yes, please bring results to your appointment.**
2. **Blood tests pertaining fertility: If yes, please bring results to your appointment.**
3. **Varicocele examination by physical or ultrasound**

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| **If yes, give results and dates:** |
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**Have you/do you suffer from any of the following? If yes, give details and dates of treatment:**

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| **Undescended testes, testicular disease or injury/vasectomy:** |  |
| **Mumps (since puberty/aged twelve):** |  |
| **Genito-urinary infections or sexually transmitted diseases:** |  |
| **Herpes, blisters or warts (please specify):** |  |

**Please answer the following questions:**

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| --- | --- |
| **Do you exercise wearing tights, synthetic shorts and/or wetsuits? Give details:** |  |
| **What style of underwear do you use?****🡪 Boxer/jockey?****🡪 Loose/tight fitting?****🡪 Synthetic/natural fibre?** |  |
| **Do you use saunas, spas or hot baths? If yes, please specify.** |  |
| **How would you rate your libido?****Strong/moderate/mild:** |  |
| **Have you received any other form of treatment for reproductive problems?****If yes, give details and dates.** |  |

**FEMALES**

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| --- | --- |
| **Have you charted your basal (body at rest) temperature? Yes/No:** |  |
| **Do your charts show a mid-cycle rise? Never/sometimes/usually/always:** |  |
| **Does your mucus change mid-cycle? Never/sometimes/usually/always:** |  |
| **On which days do you experience fertile mucus?** |  |

**Have you had any of the following investigations?**

1. **Ultrasound of uterus or pelvic region?**

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| **If yes, give results and dates:** |
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1. **Laparoscopy?**

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| **If yes, give results and dates:** |
|  |
| **Condition of fallopian tubes (clear/blocked/partially blocked):** |
| **Left:** **Right:**  |

1. **Hysterosalpingogram or Hy-Co-Sy?**

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| **If yes, specify which and gives results and dates:** |
|  |
| **Condition of fallopian tubes (clear/blocked/partially blocked):** |
| **Left:** **Right:**  |

1. **Hysteroscopy?**

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

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| --- | --- |
| **Pelvic inflammatory disease** |  |
| **Endometriosis** |  |
| **Polycystic ovarian syndrome** |  |
| **Ovarian cysts** |  |
| **Fibroids** |  |
| **Candida (thrush)** **🡪 No/occasionally/frequently****🡪 Vaginal or systemic?****🡪 How severe?****🡪 What makes it worse?****🡪 How often in the last year?** |  |
| **Genito-urinary infections or sexually transmitted diseases (including cystitis):** |  |
| **Herpes/blisters/warts (specify which):** |  |

**Please answer the following questions:**

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| --- | --- |
| **Have you had a recent pap smear?** **If yes, give results and dates:** |  |
| **Have you had cervical erosion/cone biopsy/loop incision/laser treatment /cauterisations? Give details and dates.** |  |
| **Have you even taken the oral contraceptive pill and when (from/to)?** |  |
| **Did you suffer any side effects?** **If yes, give details:** |  |
| **Did you experience a delay in the return of your cycle? If yes, give details:** |  |
| **Have you ever used an IUD?****If yes, when (from/till):** |  |
| **Did you experience any problems?** **If yes, give details and dates:** |  |
| **How would you rate your libido?****Strong/moderate/mild:** |  |

**MENSTRUAL CYCLE DETAILS**

|  |  |
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| **How often do you menstruate? What is the average length of your cycle (e.g. 27/28/29/30/31 days)?**  |  |
| **If this varies, how long is the shortest and longest cycle usually experienced?** | **Shortest (e.g. 21 days):****Longest (e.g. 42 days):**  |
| **Has it been more than 6 weeks since your last menstrual period?** **If yes, how long?** |  |
| **How many days do you bleed for?** |  |
| **Is the flow heavy, medium or light?** |  |
| **Is the blood bright or dark?** |  |
| **Are there clots in the blood?****Never, occasionally, always:** |  |
| **How would you describe these clots?****Small and stringy, small and lumpy, large and lumpy etc:** |  |
| **Do you experience spotting before your period starts? If yes, for how many days?** |  |
| **Do you experience mid-cycle spotting? If yes, give details.** |  |
| **Do you experience mid-cycle pain? If yes, give details.** |  |
| **Do you use a menstrual cup, pads, organic tampons or other tampons?** |  |
| **Do you need to take pain killers?****Never, sometimes, usually, always:** |  |
| **If you do take pain-killers, for how many days before and during your period?** | **Before:****During:**  |
| **Have there been any recent changes in your cycle? If yes, give details.** |  |

**Please answer the following if you suffer any of the menstrual symptoms listed below:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Number of Days** | **None, Slight, Moderate, Severe** | **Before or During Period** |
| Abdominal cramping  |  |  |  |
| Abdominal aching |  |  |  |
| Backache |  |  |  |
| Nausea/vomiting (specify) |  |  |  |
| Constipation |  |  |  |
| Diarrhoea |  |  |  |
| Skin problems |  |  |  |
| Sore breasts |  |  |  |
| Fluid retention |  |  |  |
| PMT |  |  |  |
| Fatigue |  |  |  |
| Food cravings |  |  |  |

**GENERAL HEALTH**

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

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| --- | --- | --- |
|  | **Female** | **Male** |
| **Cardiovascular disease (abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations etc)** |  |  |
| **Liver disease** |  |  |
| **Mental or nervous system disease** |  |  |
| **Glandular fever and/or chronic fatigue** |  |  |
| **Any other major diseases, including autoimmune diseases** |  |  |

**Please answer the following questions about digestion, and give details where necessary:**

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| --- | --- | --- |
|  | **Female** | **Male** |
| **Do you have regular (at least daily) bowel motions?** |  |  |
| **If not, on how many days in an average week?** |  |  |
| **Do you use laxatives?** **If yes, give details.** |  |  |
| **Do you experience diarrhoea, constipation, flatulence, mucus or blood in stools? Give details.** |  |  |
| **Do you experience heart burn, bloating or bad breath?** **If yes, given details.**  |  |  |
| **Do you have any malabsorption or eating disorders?** **If yes, give details.** |  |  |
| **Do you experience food cravings, if so, what for?** **If for sugar, is this principally chocolate?** |  |  |

**Please answer the following questions, and give details where necessary:**

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| --- | --- | --- |
|  | **Female** | **Male** |
| **Do you suffer from headaches or migraines?** **If yes, give details.** |  |  |
| **Do you consider yourself stressed? Give details.** |  |  |
| **Do you sleep well? Give details.** |  |  |
| **Are you tired on waking?** **If yes, give details.** |  |  |
| **How would you rate your energy levels? High/medium/low.** |  |  |
| **How often in the last year have you suffered from colds, flus or infections: Never, occasionally or frequently?** |  |  |
| **Do you have any allergies or sensitivities (including salicylate allergy and/or hay-fever)?** **If yes, give details.** |  |  |
| **Do you do any exercise? Give details (inc. frequency and length of time per week):** |  |  |

**Do you suffer (recently or to a significant degree) from any of the following? Please mark (X).**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **F** | **M** |  | **F** | **M** |  | **F** | **M** |
| Allergies |  |  | Depression |  |  | Mouth ulcers |  |  |
| Anxiety |  |  | Dermatitis or eczema |  |  | Nasal/sinus congestion |  |  |
| Back pain (lower) |  |  | Dizziness |  |  | Numbness or tingling |  |  |
| Bleeding gums |  |  | Hair loss (not balding) |  |  | Panic attacks |  |  |
| Brittle nails |  |  | Irritability |  |  | Sensitivity to light/noise |  |  |
| Bruising |  |  | Irritable bowel |  |  | Sensitivity to odours |  |  |
| Cold hands/feet |  |  | Itching |  |  | Skin problems or rashes |  |  |
| Cramps (not menstrual) |  |  | Joint/muscle pain |  |  | Sweating (excess/night) |  |  |

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| **Would you like to go on our newsletter emailing list to keep up-to-date on our seminars, recipes and clinic news?**  |
| **YES or NO:**  |

**Please include any additional information if need be, and email this questionnaire back to us at** **admin@phf.healthcare** **before your appointment. Thank you.**