Consultation Form

FEMALE FERTILTY/WOMENS HEATH

Confidential

Surname: Age:

Forename(s): Date of Birth:

Full Address:

Postcode:

Relationship Status: Weight: Height:

Number of Children: Have you recently lost or gained weight:

Mobile: Email:

Emergency contact: Emergency phone No:

Employment Details

Occupation: Employer:

Number of years in current job: Previous occupation:

Health Details

Name of GP Practice: Name of GP:

Prescribed medication currently taking:

Unprescribed medication currently taking:

Supplements currently taking:

What is the general state of your health? *Excellent* ☐ *Good* ☐ *Average* ☐ *Fair* ☐ *Poor* ☐

Any Operations/Hospitalisations:

Do you smoke? *Yes* ☐ *No* ☐ per day. Do you drink alcohol? *Yes* ☐ *No* ☐ Units per week

Your Current Health

What is your main reason for coming in today?

Please give me an overview of your situation and journey so far...

How long has this been an issue?

List in order of importance other health problems that are troubling you:

1) For how long?

2) For how long?

3) For how long?

Please list any healthcare practitioners you have seen regarding your main concern?

What were their diagnosis/thoughts?

What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)?

What is your current level of stress from 1 to 10 (where 10 is the most stressed)?

Please list the 2 most significant stressful events in your life:

1) Date:

2) Date:

Are any of these situations continuing to impact your life *Yes* ☐ *No* ☐ *(If yes, 1)* ☐ *or 2)* ☐ *)*

Do you suffer with anxiety? *Yes* ☐ *No* ☐ Do you suffer from depression? *Yes* ☐ *No* ☐

Are you currently working with a professional counsellor, psychologist, or any other therapist? *Yes* ☐ *No* ☐

Have you in the past?

Do you exercise? *Yes* ☐ *No* ☐ *If yes, what do you do and how often?*

On a scale of 1-10, how would you rate the quality of your sleep (10 being great)

Do you have a problem falling asleep? *Yes* ☐ *No* ☐ Staying asleep? *Yes* ☐ *No* ☐

How much do you sleep per night? hours How many hours do you think you need? hours

Are you vegetarian or vegan? *Vegetarian* ☐ *Vegan* ☐ *No* ☐

How is your body temperature, compared to others? *Warmer* ☐ *Cooler* ☐ *Average* ☐

Do you break out in sweats during the day? *Yes* ☐ *No* ☐ Do you break out in sweats during the night? *Yes* ☐ *No* ☐

Do you enjoy your work? *Yes* ☐ *No* ☐ On a scale of 1-10 how much does it cause stress? (10 being the most)

How often do you get colds, flu or sore throats per year?

Digestion

Do you have any problems with gas, bloating, or fullness after eating? *Yes* ☐ *No* ☐

How often is this a problem? *Often* ☐ *Sometimes* ☐ *Never* ☐

How severe?

How long have you had this problem? How often do you have bowel movements

Do you ever have any blood, mucous or undigested food in your stool? *Often* ☐ *Sometimes* ☐ *Never* ☐

Are your stools formed or loose?

Do you ever have alternating constipation and diarrhoea? *Yes* ☐ *No* ☐ *If yes, how often*

Vaginal Health

Do you have any problems with thrush? *Yes* ☐ *No* ☐ *If yes, when was the last episode?*

How often is this a problem? *Once* ☐ *Often* ☐ *Sometimes* ☐ *Other* ☐

Do you have problems with Bacterial Vaginosis? *Yes* ☐ *No* ☐ *If yes, when was the last episode?*

How often is this a problem? *Once* ☐ *Often* ☐ *Sometimes* ☐ *Other* ☐

Please tick if any of the following apply to you:

- o Epilepsy ☐
- o If you are taking anticoagulant medications ☐
- o Do you have surgeries scheduled? ☐
- o Hemophiliac ☐
- o Wear a pacemaker ☐
- o Have a serious heart or lung condition ☐

Women's Health History

What age did your period begin? _____ First day of your last period? _____

Are your periods painful? *Yes* ☐ *No* ☐ If yes, how many days does the last pain last? _____

How would you rate the pain? *Mild* ☐ *Moderate* ☐ *Severe* ☐

How heavy is the bleeding? *Light* ☐ *Medium* ☐ *Heavy* ☐

What colour is the blood? *Light Red* ☐ *Red* ☐ *Dark Red* ☐ *Purple* ☐ *Brown* ☐ *Black* ☐

Is there clotting? *Yes* ☐ *No* ☐ Do you have premenstrual mood swings? *Yes* ☐ *No* ☐

Does your face break out before or during your period? Yes ☐ No ☐ Do your breasts become tender? *Yes* ☐ *No* ☐

Do you bleed or spot between periods? *Yes* ☐ *No* ☐ Are your menstrual cycles spaced irregularly? *Yes* ☐ *No* ☐

Cycle length (i.e 26, 28, 35) _____ How many days do you normally bleed? _____

Pregnancies? _____ How many children do you have? _____ How many miscarriages had? _____ D&C performed? _____

Have you ever had an abnormal smear? *Yes* ☐ *No* ☐

Have your cycles changed since they began? *Yes* ☐ *No* ☐

If so How? _____

Do you ovulate on your own? *Yes* ☐ *No* ☐ *If known, on what day of your cycle?* _____

Do you notice breast tenderness around ovulation? *Yes* ☐ *No* ☐ Do you experience ovulation pains? *Yes* ☐ *No* ☐

Do you have increased cervical mucus around ovulation? *Yes* ☐ *No* ☐

Do you chart your BBT and/or cervical mucus? *Yes* ☐ *No* ☐

Have you taken medication to help you ovulate? *Yes* ☐ *No* ☐ *If yes, which?* _____

When? How long? _____

Have you ever been diagnosed with uterine fibroids or polyps or cysts? *Yes* ☐ *No* ☐

If yes, what and where? _____

Have you ever been diagnosed with any pelvic abnormalities? *Yes* ☐ *No* ☐

If yes, what and where? _____

Do you have excess facial or body hair? *Yes* ☐ *No* ☐

Have you ever taken any medications for gynaecological conditions other than contraceptives? Yes ☐ *No* ☐

Medication _____ Reason _____

Have your fallopian tubes been evaluated medically? *Yes* ☐ *No* ☐

What were the results? _____

Have you had any hormone laboratory tests performed? *Yes* ☐ *No* ☐ *(If yes please forward lab reports)*

If with a male partner has he had a fertility check? *Yes* ☐ *No* ☐ *(If yes please forward lab reports)*

Is your partner supportive of your wish to conceive? *Yes* ☐ *No* ☐ Is sex painful? *Yes* ☐ *No* ☐

How is your sexual libido? *Low* ☐ *Medium* ☐ *High* ☐

How frequently do you have sex if you are ttc? _____

Have you taken oral contraceptives? *Yes* ☐ *No* ☐

When? How long? _____

Have you ever had an IUD coil? *Yes* ☐ *No* ☐

When? How long? _____

Have you had a diagnosis relating to infertility? If yes, what was it?

If you have had fertility treatment please state what type and when.

Do you have any other health matter/specific questions NOT covered that should be brought to our attention?

How did you find out about my clinic? *Please circle.* Friend (_____), Fertility Clinic, Doctor, Flyer, Instagram, Google, BAF, Magazine, Other: _____

I appreciate the time taken to complete these forms, I understand that they can be extremely personal and sometimes questions can repeat themselves or seem unrelated.

The answers help me to understand what is currently going on in your body, then following seeing you in person enables me to put a treatment plan together specifically for you.

Thank you again and I look forward to speaking with you.

Angie