

# Consultation Form

F E M A L E F E R T I L T Y / W O M E N S H E A T H

## 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: \_\_\_\_\_

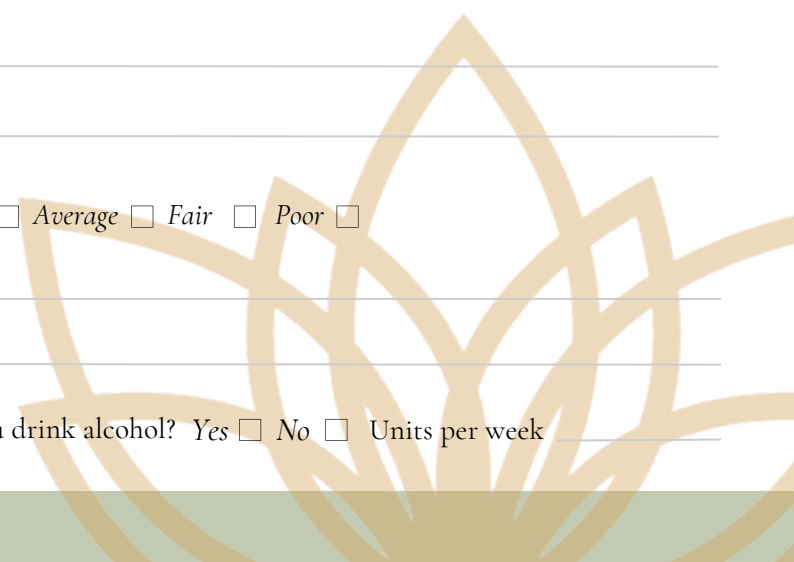
Unprescribed medication currently taking: \_\_\_\_\_

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?

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

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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? \_\_\_\_\_

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What were their diagnosis/thoughts?

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

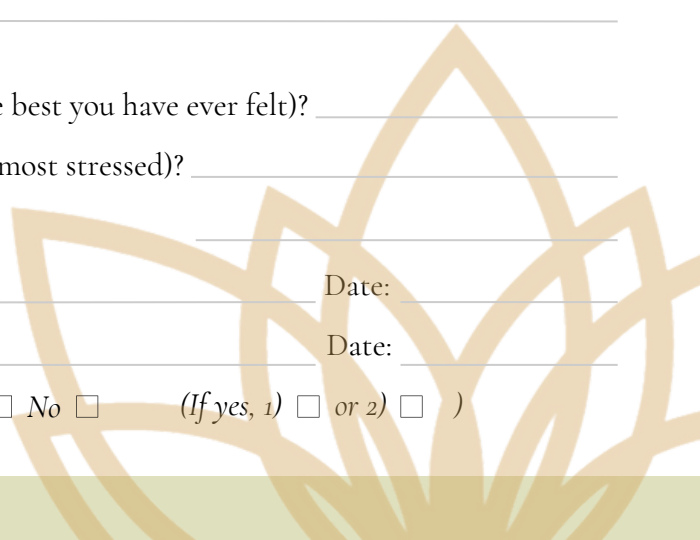
What is your current level of stress from 1 to 10 (where 10 is the most stressed)? \_\_\_\_\_

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? \_\_\_\_\_

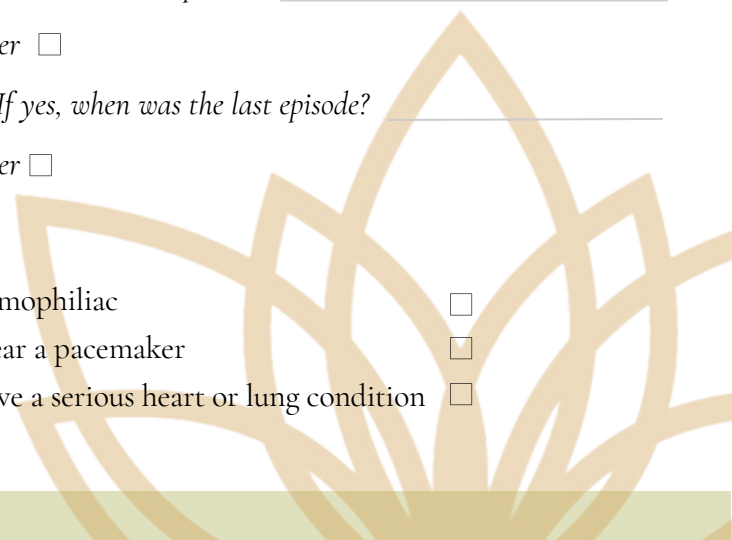
How often is this a problem? Once  Often  Sometimes  Other

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:

- |  |   |
|--|---|
| <input type="checkbox"/> Epilepsy                                    | <input type="checkbox"/> Hemophiliac                            |
| <input type="checkbox"/> If you are taking anticoagulant medications | <input type="checkbox"/> Wear a pacemaker                       |
| <input type="checkbox"/> Do you have surgeries scheduled?            | <input type="checkbox"/> 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

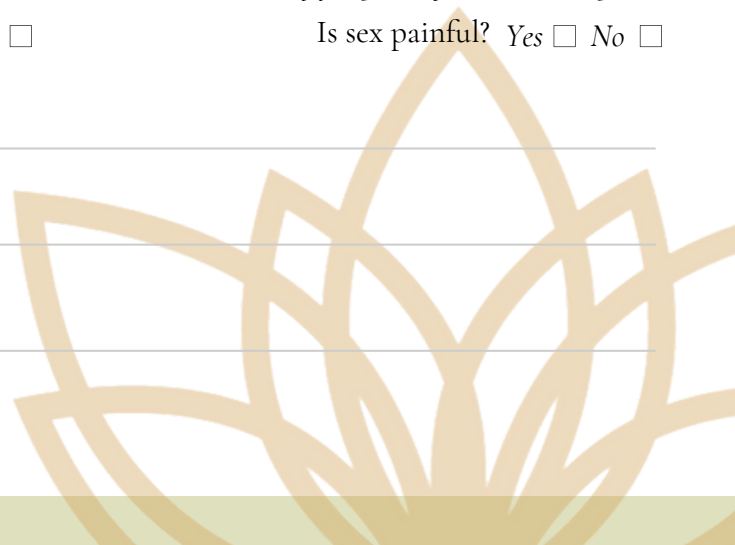
How frequently do you have sex if you are TTC? \_\_\_\_\_

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*

