FIRST VISIT REPRODUCTIVE HEALTH QUESTIONNAIRE

Shire Natural Fertility & Burraneer Wellness

Please note this information is strictly confidential

Part 1: Patient General Information

Given Name: _____ Surname: _____

Preferred Name:_____ Date of Birth:_____

Name of GP: _____ Health Fund:_____

Occupation:_____

Partners General Information

Given Name: _____ Surname: _____

Preferred Name:_____ Date of Birth:_____

Name of GP: _____ Health Fund:_____

Occupation:_____

Home Address: _____

Suburb: _____ State: _____ Pot Code: _____

Telephone Home: _____ Work: _____ Mobile: _____

Preferred email: _____

Have either of you been diagnosed with any of the following conditions?

Condition	Female	Male
Asthma		
Skin Conditions (Eczema, Dermatitis, Psoriasis)		
Diabetes Type I or II		
Thyroid Conditions (Hypo or Hyper)		
Gout or Arthritis		
Cardiovascular Disease or Hypertension		
Cancer (please specify_____)		
Allergies (_____)		
Sinusitis		
Gastrointestinal Conditions (IBS, Ulcerative, Crohn's disease)		
Depression or Anxiety		

Please list any medications or supplements you take?

Female	Male

Part 2: Reproductive History

Have you previously conceived? **Yes/No**

If yes, what were the results of these previous conceptions:

Full-term pregnancy **Yes/No** Ages of your children: _____

Miscarriage **Yes/No** Year & Month if known:_____

Other **Yes/No** Year & Month if known:_____

Are you currently using contraception **Yes/No** Method: _____

How long have you been using this method? _____

Have you ever taken the contraceptive pill? **Yes/No** If Yes when? From:_____ To_____

Did you suffer from any side effects? **Yes/No** If so give details _____

Have you charted your basal (body at rest) temperature? **Yes/No**

Have you charted your cervical mucus? **Yes/No**

Were these methods successful for you? **Yes/No** Comment? _____

_____

ART (Assisted Reproductive Technology)

Have you undergone or are currently undergoing any of the following ART Procedures:

- Ovulation Induction **Yes/No** (please give year & month) _____
- IUI: **Yes/ No** (please give year & month) _____

Name of Fertility Specialist & Centre:_____

Male Reproductive Health

Has your partner had any of the following medical investigations:

- Semen Analysis **Yes/No** _____
- Blood tests for hormone levels **Yes/No** _____

Rate your Libido **STRONG / MODERATE / MILD** _____

Female Reproductive Health

Have you been diagnosed with any of the following conditions?

Endometriosis **Yes/No**_____

Fibroids **Yes/No**_____

PCOS (Polycystic Ovarian Syndrome) **Yes/No**_____

Candida (thrush) No/Occasionally/Frequently_____

Genito-Urinary Infections (Cystitis) **Yes/No**_____

Sexually Transmitted Disease **Yes/No**_____

Herpes/Blisters/Warts **Yes/No**_____

Rate your Libido **STRONG / MODERATE / MILD** _____

Menstrual Cycle Details

How often do you have a period? Your average length of cycle is _____ days

If this varies, give the shortest cycle experienced _____ days and the longest cycle _____days

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

Do you experience mid-cycle spotting? **Yes/No**_____

Do you experience mid-cycle pain? **Yes/No**_____

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			
Backache			
Nausea/Vomiting			
Headache			
Constipation/Diarrhea			
Skin problems			
Sore breasts			
Fluid retention			
PMT			
Fatigue			
Food cravings			