Shire Natural Health & Fertility

FIRST VISIT REPRODUCTIVE HEALTH QUESTIONNAIRE

STRICTLY CONFIDENTIAL

PART 1: GENERAL INFORMATION

Patient details

First name:		Last name:	
Preferred name:		Date of birth:	
Occupation			
Name of GP:		Health fund:	

Partner's details

First name:		Last name:	
Preferred name:		Date of birth:	
Occupation			
Name of GP:		Health fund:	

Contact details

Home address:					
Suburb:		State:		Postcode:	
Home phone:		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 (specify)		
Allergies (specify)		
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

	Yes	No			
Have you previously conceived:					
If yes, what were the results of these previous conceptions:					
Full-term pregnancy			Ages of your children:		
Miscarriage			Year & month if known:		
Other			Year & month if known:		
Are you currently using contraception?			Method:		
How long have you been using this method?					
Have you ever taken the contraceptive pill?			If yes:	From:	To:
Do you suffer from any side effects?			If so, give details:		
Have you charted your basal (body at rest) temperature?					
Have you charted your cervical mucus?					
Were these methods successful for you?					
Any additional information we should know?					

ART (Assisted Reproductive Technology)

Have you undergone or are currently undergoing any of the following ART procedures?

	Yes	No		
Ovulation Induction			Year & month:	
IUI			Year & month:	
Name of Fertility Specialist:				
Name of Fertility Centre:				

Male reproductive health

Has your partner had any of the following medical investigations?

	Yes	No
Semen Analysis		
Blood tests for hormone levels		

Rate your partner's libido: Strong ☐ Moderate ☐ Mild ☐

Female reproductive health

Have you been diagnosed with any of the following conditions?

Condition	Yes	No
Endometriosis		
Fibroids		
PCOS (Polycystic Ovarian Syndrome)		
Candida (thrush)		
Genito-Urinary Infections (Cystitis)		
Sexually Transmitted Disease		
Herpes / Blisters / Warts		

Occasionally ☐ Frequently ☐

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? _____ days

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 Period	During Period
Abdominal cramping							
Backache							
Nausea / vomiting							
Headache							
Constipation / diarrhea							
Skin problems							
Sore breasts							
Fluid retention							
PMT							
Fatigue							
Food cravings							