

# health & fertility matters

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

DOB: \_\_\_\_\_

Mobile: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

Household Situation: \_\_\_\_\_

Children: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Are you currently being treated? YES/NO**

If so, who is treating you and what are you being treated for?

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**Are you taking any medications or nutritional medicine? YES/NO**

If so, what are you taking?

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**Have you ever suffered from any of these conditions?**

**If yes, please give details.**

**Digestive System Disorders: YES/NO**

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**Kidney or Bladder Disorders: YES/NO**

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**Liver Disease: YES/NO**

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**Asthma or Respiratory Disorders: YES/NO**

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**Cardio-vascular Disease** (including abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations): YES/NO

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**Nervous System Disorders: YES/NO**

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**Eczema/Psoriasis/Skin Conditions: YES/NO**

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**Diabetes: YES/NO**

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**Autoimmune Disorders including Thyroid: YES/NO**

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**IS:**

Occurrence and severity of coughs, colds, flus and Infections/ Swollen glands/ Allergies/ Sensitivities

**GIT:**

Appetite/ nausea/ reflux/ vomiting/ burping/ breath/ flatulence/ bloating/ reaction to fatty foods/ reaction to missing meals/ weight problems

**Bowels:**

How often, constipation/diarrhea, loose/formed, mucous/blood, laxative use

**RS:**

Asthma/ hay fever/ sinus/ post nasal drip/ cough/ SOB/ smoking

**US:**

Bladder or kidney problems/ Cystitis/ incontinence/ UTI's/ thirst/ nocturia

**CVS:**

Abnormal BP/ high cholesterol/ angina/ palpitations/chest pain/ varicose veins/ poor circulation/ cold hands and feet

**MSS:**

Cramping/ muscle pain/ back pain/ stiffness

**NS:**

Migraines/ Headaches/ mood swings/ anxiety/ depression

**Skin:**

Eczema/ Acne/ Psoriasis

**MRS:**

Infections, lymph swelling, impotence, hernia

**Female Reproductive System:**

Are you presently using contraception or hormone active drugs:

If so, what are you taking?

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**Do you, or have you, suffered from any of the following?**

Pelvic Inflammatory Disease: YES/NO

Endometriosis: YES/NO

Cystitis: YES/NO

Ovarian Cysts: YES/NO

Polycystic Ovarian Syndrome: YES/NO

Fibroids: YES/NO

Candida/ Thrush: YES/NO

If yes, is it vaginal or systemic? \_\_\_\_\_

Severity: \_\_\_\_\_

What makes it worse?

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Do you, or have you had a sexually transmitted disease? YES/NO

Herpes/ blisters/ Warts: YES/NO

Have you ever had an abnormal pap smear? YES/NO

Details: \_\_\_\_\_

Have you ever conceived? YES/NO

Details: \_\_\_\_\_

What is the average length of your cycle? \_\_\_\_\_

How many days do you bleed for? \_\_\_\_\_

Is the flow heavy/ medium/ light? \_\_\_\_\_

Is the blood bright/dark? \_\_\_\_\_

Do you have any clotting in the blood? \_\_\_\_\_

Do you ever experience mid-cycle spotting? \_\_\_\_\_

Do you ever experience mid-cycle pain? \_\_\_\_\_

**Do you suffer any of the following pre menstrual symptoms?**

Abdominal cramping/aching: YES/NO

Backache: YES/NO

Nausea/ Vomiting: YES/NO

Headaches: YES/NO

Constipation/Diarrhea: YES/NO

Skin problems: YES/NO

Sore breasts: YES/NO

Fluid retention: YES/NO

PMT: YES/NO

Fatigue: YES/NO

Food cravings: YES/NO

Do you take pain killers? YES/NO

If yes, how often?

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Have there been any recent changes in your cycle? YES/NO

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Is there anything else that needs mentioning in relation to your cycle?

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**LIFESTYLE**

Do you sleep well? \_\_\_\_\_

How many hours sleep a night do you have? \_\_\_\_\_

Do you wake refreshed? \_\_\_\_\_

Do you exercise? YES/NO

Type of exercise and hours per week: \_\_\_\_\_

How would you rate your energy levels? 0-10 \_\_\_\_\_

How many hours a week do you work? \_\_\_\_\_

**DIET**

Breakfast: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Lunch: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dinner: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Snacks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drinks: \_\_\_\_\_

Water: \_\_\_\_\_

Tea/coffee: \_\_\_\_\_

Alcohol: \_\_\_\_\_

Cigarettes: \_\_\_\_\_

Do you have any specific cravings or aversions?

\_\_\_\_\_

\_\_\_\_\_

Are you allergic or sensitive to any food?

\_\_\_\_\_

\_\_\_\_\_

## PHYSICAL EXAMINATION

Nails: \_\_\_\_\_

Tongue: \_\_\_\_\_

### **IRIS**

Colour:

Pupil:

Texture:

GIT:

Acid:

Lymph:

ANW:

Nerve Rings:

Lesions:

Skin:

Circulation: