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# REPRODUCTIVE HEALTH QUESTIONNAIRE

*Please attach to this completed form copies of any past pathology results including blood tests, ultrasound reports and any other medical reports. These can be requested by you from your GP or specialist and should be organized prior to your appointment.*

Date of Consultation: ____________________ Referred by: ______________________

**Female General Information**

Given name: ____________________ Surname: __________________________

Date of birth: ____________________ Age: _____________________________

Occupation: ____________________ Email: ____________________________

Telephone Home: _____________ Work: ____________ Mobile: ___________________

Height: ___________________________ Weight: ______________________________

Name of GP: ______________________ Name of Specialist: _______________________

□ Tick if you would prefer not to receive our emails

**Male General Information**

Given name: ____________________ Surname: _____________________

Date of birth: ____________________ Age: _____________________________

Occupation: ____________________ Email: ____________________________

Telephone Home: _____________ Work: ____________ Mobile: __________________

Height: ___________________________ Weight: ______________________________

Name of GP: ______________________ Name of Specialist: _____________________

Home address: ______________________________________________________

Suburb: __________________ State: _________ Postcode: _____________

□ Tick if you would prefer not to receive our emails

Please list any medications or supplements you take:

| Medication/supplement (Female) | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| **Medication/supplement (Male)** | **Dosage** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Reproductive Health** (Please circle yes or no)

How long have you been trying to conceive? : ____________________________________

Have you previously conceived? Female **Yes No** Male **Yes No**

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

Full term pregnancy **Yes No** Ages of your children: __________________
Miscarriage **Yes No** Year and month if known: ________________
Stillbirth **Yes No** Year and month if known: ________________
Other **Yes No** Year and month if known: _______________
Were these conceptions a result of natural conception or Assisted Reproductive Technologies?

_____________________________________________________________________________

Were these conceptions a result of your relationship with your current partner? **Yes No**

**Assisted Reproductive History (ART)**

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

| Procedure | Dates | Details |
|---|---|---|
| Clomiphene/Clomid | | |
| IUI | | |
| IVF | | |
| ICSI | | |
| PICSI | | |

Further information regarding outcomes of these treatment cycles eg. specialist, clinic, number of cycles, drugs used etc.

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Female Reproductive History**

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

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

Have you used ovulation predictor kits? **Yes No**

If yes, what day/days do you ovulate? ______________________________________

Were these methods successful for you? **Yes No**

Comment?_____________________________________________________________

Have you undergone any pelvic/uterine surgery? **Yes No**

If yes give details: ______________________________________________________

How would you rate your libido? **STRONG / MODERATE / MILD**

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

| Condition | Dates | Treatment Details |
|---|---|---|
| Endometriosis / Adenomyosis | | |
| PCOS (Polycystic Ovarian Syndrome) | | |
| Fibroids | | |
| Candida (thrush) | | |
| Genito-urinary infections (cystitis) | | |
| Sexually transmitted disease (details) | | |
| Genital Herpes/blisters/warts | | |
| Pelvic inflammatory disease | | |
| Ovarian cysts | | |
| Pain or bleeding during /after intercourse | | |

Have you undergone any of the following investigations?

| Investigation | Please tick if Yes |
|---|---|
| Ultrasound | |
| Hycosy | |
| Hysterosalpingogram | |
| Hysteroscopy | |
| Laparotomy | |
| Laparoscopy | |
| Colposcopy | |
| Laser treatment | |
| Hormone levels | |
| Thyroid function | |

* Please attach copies of all relevant investigations/results

**Menstrual Cycle Details**

How old were you when you had your first menstrual cycle? ______________________

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 _______days

How many days do you bleed for? ___________________________________________

Is the flow **HEAVY / MEDIUM / LIGHT** Is the bleed **BRIGHT / DARK**

Do you experience mid-cycle spotting? **Yes No** Do you experience mid-cycle pain? **Yes No**

Are you presently undergoing any hormonal treatment? Please specify.

_____________________________________________________________________________

Do you need painkillers during your period? **Yes No** Names and doses

_____________________________________________________________________________

Give the number of days, severity and timing if you suffer from the following symptoms:

| | None/slight/moderate/severe | No. of days | Before/during period |
|---|---|---|---|
| Abdominal cramping | | | |
| Backache | | | |
| Nausea/vomiting | | | |
| Headache | | | |
| Constipation/diahorrea | | | |
| Skin problems | | | |
| Sore breasts | | | |
| Fluid retention | | | |
| PMT | | | |
| Fatigue | | | |
| Food cravings | | | |
| Spotting | | | |

Have there been any recent changes to your cycle? **Yes No**

_____________________________________________________________________________

_____________________________________________________________________________

**Contraception History**

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, please list the name of the contraceptive pill and for how long you were taking it:

_____________________________________________________________________________

Did you suffer from any side-effects? **Yes No**

If yes give details: _____________________________________________________

Please list any other methods of contraception previously used:

____________________________________________________________

## Digestive Health

Do you experience any of the following?

**Male**

- ☐ Bloating
- ☐ Flatulence
- ☐ Reflux/Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food intolerances

**Female**

- ☐ Bloating
- ☐ Flatulence
- ☐ Reflux/Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food intolerances

**Male to complete**

Do you take any medications such as antacids, laxatives, antibiotics, aspirin or anti-inflammatory medication? Name of medication and frequency.

_______________________________________________

_______________________________________________

Have you had any medical investigations such as colonoscopy, endoscopy?

_______________________________________________

_______________________________________________

**Female to complete**

Do you take any medications such as antacids, laxatives, antibiotics, aspirin or anti-inflammatory medication? Name of medication and frequency.

_______________________________________________

_______________________________________________

Have you had any medical investigations such as colonoscopy, endoscopy?

_______________________________________________

_______________________________________________

**Male Reproductive Health**

Have you had any of the following medical investigations?

| Condition | Yes/No | Date/Details |
|---|---|---|
| Semen Analysis | | |
| Blood tests for hormone levels | | |
| Blood tests for thyroid function | | |
| Ultrasound | | |

Have you undergone any surgery to your reproductive organs?

| Condition | Yes/No | Date/Details |
|---|---|---|
| Vasectomy | | |
| Varicocele | | |
| Undescended testes | | |
| Hypospadias | | |
| Testicular disease/disorders | | |
| Prostate disease | | |

* Please attach copies of all relevant investigations/results

Do you use saunas/spas/hot baths/bike ride regularly/wear wetsuits? **Yes No**

Any history of sexually transmitted disease (including herpes)? **Yes No**

Any history of mumps since puberty? **Yes No**

Have you used any treatments for hair loss? **Yes No**

Do you regularly use cold and flu tablets, anti-inflammatory or allergy medications? **Yes No**

Any history of hormonal or steroid use? **Yes No**

Have you received any other forms of treatment for reproductive problems? **Yes No**

Please provide dates/details ________________________________________________

__________________________________________________________________________

How would you rate your libido? **STRONG / MODERATE / MILD**

**Lifestyle (Male & Female)**

| Lifestyle | Female | Male |
|---|---|---|
| Do you smoke cigarettes or have you in the past? If yes, please give details: how long? How many per day? | Please specify: | Please specify: |
| Do you consume caffeinated beverages/foods such as coffee/tea/energy drinks/chocolate? | Please specify: | Please specify: |
| Do you consume alcohol? | Amount per week: | Amount per week: |
| Do you take any recreational drugs? | Please specify: | Please specify: |
| Do you exercise and what type? | Amount per week: | Amount per week: |
| Please rate your stress levels: low/medium/high | Further details: | Further details: |
| Please rate your energy levels: low/medium/high | Further details: | Further details: |
| Do you experience problems with sleep quality? | Further details: | Further details: |

**Medical History – Self and family - please tick boxes if relevant**

Have you or any of your family been diagnosed with any of the following conditions?

| **Conditions** | **Self Female** | Female Mother's side | Females Father's side | **Self Male** | Male Mother's side | Male Father's side |
|---|---|---|---|---|---|---|
| | | | | | | |
| Allergies | | | | | | |
| Arthritis | | | | | | |
| Asthma | | | | | | |
| Autoimmune disease | | | | | | |
| Bowel disorder | | | | | | |
| Cancer | | | | | | |
| Cardiovascular disease | | | | | | |
| Depression | | | | | | |
| Diabetes | | | | | | |
| Eczema or Psoriasis | | | | | | |
| Epilepsy | | | | | | |
| Endometriosis | | | | | | |
| Fibroids | | | | | | |
| Gastroenteritis/Giardia etc | | | | | | |
| Hepatitis | | | | | | |
| Hospitalisations/operations | | | | | | |
| Hysterectomy | | | | | | |
| Infertility | | | | | | |
| Miscarriage | | | | | | |
| Osteoporosis | | | | | | |
| Sexually transmitted disease | | | | | | |
| Thyroid disease | | | | | | |
| Other | | | | | | |

## 3 DAY DIET DIARY

This diet diary should be completed prior to your appointment with your naturopath and brought with you to your appointment. Please include as much details as possible eg. Type of bread used on sandwiches, whether food is packaged, takeaway or fresh, any dressings or oils used in cooking, any drinks etc….

## FEMALE

| DAY 1 | DAY 2 | DAY 3 |
|---|---|---|
| Breakfast | Breakfast | Breakfast |
| Morning snack | Morning snack | Morning snack |
| Lunch | Lunch | Lunch |
| Afternoon snacks | Afternoon snacks | Afternoon snacks |
| Dinner | Dinner | Dinner |
| Other snacks | Other snacks | Other snacks |

Water Intake per day –

Coffee/teas per day –

Alcohol per day –

**3 DAY DIET DIARY**

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**MALE**

| DAY 1 | DAY 2 | DAY 3 |
| --- | --- | --- |
| Breakfast | Breakfast | Breakfast |
| Morning snack | Morning snack | Morning snack |
| Lunch | Lunch | Lunch |
| Afternoon snacks | Afternoon snacks | Afternoon snacks |
| Dinner | Dinner | Dinner |
| Other snacks | Other snacks | Other snacks |

Water Intake per day –

Coffee/teas per day –

Alcohol per day –