



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
<u>Breakfast</u>	<u>Breakfast</u>	<u>Breakfast</u>
<u>Morning snack</u>	<u>Morning snack</u>	<u>Morning snack</u>
<u>Lunch</u>	<u>Lunch</u>	<u>Lunch</u>
<u>Afternoon snacks</u>	<u>Afternoon snacks</u>	<u>Afternoon snacks</u>
<u>Dinner</u>	<u>Dinner</u>	<u>Dinner</u>
<u>Other snacks</u>	<u>Other snacks</u>	<u>Other snacks</u>

Water Intake per day –

Coffee/teas per day –

Alcohol per day –

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MALE

DAY 1	DAY 2	DAY 3
<u>Breakfast</u>	<u>Breakfast</u>	<u>Breakfast</u>
<u>Morning snack</u>	<u>Morning snack</u>	<u>Morning snack</u>
<u>Lunch</u>	<u>Lunch</u>	<u>Lunch</u>
<u>Afternoon snacks</u>	<u>Afternoon snacks</u>	<u>Afternoon snacks</u>
<u>Dinner</u>	<u>Dinner</u>	<u>Dinner</u>
<u>Other snacks</u>	<u>Other snacks</u>	<u>Other snacks</u>

Water Intake per day –

Coffee/teas per day –

Alcohol per day –