PCOS Centre

Online Fertility Treatment Form

Confidential Client Health Summary

Full Names Self & Partner:

_____

DOB(Female): _____/_____/_____ Age: _____ DOB(Male): _____/_____/_____ Age: _____

Home Phone: _____ Mobile (female): _____

Email: _____

Postal Address: _____

_____

Are you seeing any other naturopaths or natural health practitioners for PCOS or Fertility? _____

If so, what have they prescribed or what are they proposed treatments? _____

_____

History

How long have you been trying to conceive? _____Any pregnancies/miscarriages? _____

When? _____ What tests have been done (Male & female)? _____

_____

Past IVF treatments? _____ When? _____

Outcome? _____

Proposed IVF etc? what, when & where? _____

Other than fertility, are there any other major concerns you wish to address? _____

_____

Current Medications and Natural Supplements (Male)

Name	Reason	Duration	Dosage

Current Medications and Natural Supplements (Female)

Name	Reason	Duration	Dosage

Please indicate if you, your partner or family members has or has had any of the following conditions. For family history - Parents, siblings or grandparents use (Female) or (Male) to indicate which side this relates to.

	Female	Male	Family History
Alcoholism			
Allergies, hay fever, sinusitis			
Anaemia, Blood clotting disorders			
Asthma, bronchitis, lung disease			
Cancer, Leukaemia			
Coeliac /Crohn disease/sensitivities			
Depression/mental health disorders/Anxiety			
Diabetes			
Headaches, Migraines			
Heart disease, hypertension			
Hemochromatosis, Jaundice			
Immune disorders, Colds/Flu/ lupus/ SLE			
Infectious disease (HIV, hepatitis etc)			
Lumps/cysts/tumours			
Obesity, oedema			
Viral infections- Ross river etc			
Sexually Transmitted Diseases			
Stroke, Neural disorders			
Thyroid disorders			
Varicose veins, thrombosis, Varicocele			
Arthritis			
Other			

Naturopathic Treatment

The role of a natural therapist in your health is not to replace your medical doctor but where possible to work in conjunction with your medical practitioner or other treatments, to bring about improvement in your fertility, health and wellbeing.

Contact

As part of your treatment I will need to contact you to see how you are responding and to get further information. This will be mostly done via email but if I am unable to reach you, I may phone or text you.

Confidentially: Any personal information you provide to this clinic, will be treated with strict confidentiality. However, as fertility requires joint treatment protocols it may be necessary to use confidential information in the following ways.

- Discuss your health, progress or test results with your partner if or when you are unavailable, unless a matter has been disclosed privately to me and express confidentiality has been requested on a sensitive matter.
- Refer to a third party i.e. doctor, specialist, fertility clinic, laboratory etc as part of your treatment protocol. This usually means disclosing the relevant health information needed for further assessment.
- Gather any relevant reports, information and health history from your past or current medical or non-medical practitioners that may be required for the purpose fertility treatment.

Any of the above will only be done with your express verbal permission and full understanding at the time.

Cancellation Policy: No refund will apply for change of mind, or lack of conception during or following this treatment. As mentioned on the website I will do my utmost to give you the best chance of conception but cannot guarantee that conception or cycle changes or regulation will happen for you while in treatment on in the months following.

Disclaimer: It is important that you understand that I am a Homoeopath & Natural Therapist, and not a Medical Doctor. As such, certain conditions, diseases or illness may require referral to a medical doctor for full diagnosis and treatment.

Please note that if you wish to disclose any sensitive matters relating to your treatment you may contact me by phone or email following the consultation. This information will be treated in strictest confidence.

I/We have read the above information and I have answered the questions relating to my medical history to the best of my knowledge. I/we acknowledge that any lack of full disclosure may hinder treatment and the results thereof. I/We understand the above.

Client/s Signature: _____ **_____**

Date: _____

pcos centre

hormones . health . weight . natural fertility

PCOS Fertility Treatment Questionnaire

Please answer each question, for both partners where possible, with full details and dates. Please answer as honestly as possible – there are no right or wrong answers. **All information will be treated with strictest confidence**. Please feel free to contact me separately should there be any sensitive issues you would prefer not to disclose on this form.
Please scan & email or post the completed form to the clinic. Once I receive the information and your payment, I will put together a treatment plan for you.

Full Name/s: _____

Date: _____

Lifestyle/ Environment

What is your occupation? (please list specific activities)

Female: _____ Previous occupation:_____

Male: _____ Previous: _____

Hobbies, sports and other activities

Female: _____

Male: _____

Please complete the following: Please circle those applicable, if unsure just leave blank.

	Female (yes/no)	Male (yes/no)
In the past two years have any of your activities involved frequent contact with chemicals including: manufacture or degrading of plastics; paints; new carpets; new car; refrigeration or air-conditioning gases; glues; chemical cleansers or insecticides; frequent handling carbonless copy paper; unfiltered water; pest control; hair chemicals such as colouring or perming agents? Please circle and give details and dates: Female: _____ Male: _____		
In the past two years have any of your activities involved contact with heavy metals? Possible exposure on mine sites etc? If yes give details and dates: Female: _____ Male: _____		

Have you had any X-rays (including dental) in the past three years? If yes give details and dates: Female:_____ Male: _____		
Have you flown extensively in the past 3 years? If so, give details of frequency. Female:_____ Male: _____		
Do you regularly store your mobile phone in your pocket or on your body? Female:_____ Male: _____		
Do you use a computer? If so, how many hours/day? Circle appropriate Female: _____ hrs. (laptop/desktop/tablet) Male: _____ hrs. (laptop/desktop/tablet)		
Do you use a microwave oven? If yes how often? Female: _____ Male: _____		
Do you use any recreational drugsl? If yes, give details, type, amount, frequency and when you began: Female: _____ Male: _____		
Do you smoke cigarettes? If yes, what strength and how many per day/week, when you began. If you have quit, when did you quit? Female: _____ Male: _____		
Do you drink coffee, caffeine containing drinks or tea? If yes give details of what, how often and how much. Female: _____ Male: _____		

Do you drink alcohol? If yes, give details, type, amount, frequency and when you began: Female: _____ Male: _____		
Do you use a water filter system? At work or home? What type? _____		

REPRODUCTIVE HEALTH

Have you already started trying to conceive? **YES/NO** If so when? _____

Have you or your partner had any previous conceptions or children?

Female: _____ Male: _____

Specify whether **live birth/ miscarriage/ termination/premature/small for dates/perinatal death/stillbirth**. Give details & dates and how long it took to conceive each one: _____

_____

_____

Were these conceptions a result of your relationship with your current partner? **YES/NO**

Has your current partner been responsible for any conceptions (other partners) other than those specified above? **YES/NO** Give details: _____

FEMALE SECTION

What age did your periods commence? _____

When did they become regular? Was that on their own or on the pill? _____

When were you first diagnosed with PCOS? _____

Was the diagnosis via blood tests and or ovarian ultrasounds? _____

What are your most frustrating symptoms? Irregular cycle, no cycles, lack of ovulation, heavy or painful periods, low libido, weight gain, depression, anxiety, hirsutism (facial or body hair), hair loss or balding, other? _____

_____

Have you used ovulation prediction tests? If yes, did you notice any positive results? If so what day of your cycle?

_____

_____

Have you previously temperature charted your cycle? (if yes, please email me a copy) **YES/ NO**

- Did you show a mid-cycle temperature rise? **Never/sometimes/usually/always** – what day was your temperature rise on average?

Have your observed changes to your cervical discharge/mucus during your cycle? **YES/NO**

- Do you regularly look for mucus changes? **Never/sometimes/usually/always**
- Does your mucus change mid-cycle? Have you notice raw egg white (fertile) type discharge? **Never/sometimes/usually/always**
- On what days do you generally notice fertile mucus, how would you describe it? _____
  _____

Have you previously had any of the following medical investigations done? Give details and dates

a) Blood tests to show hormone levels **YES/NO**, were these done while on fertility drugs? **YES/NO**
   Email in copies of any results if possible. Give details and results: _____
   _____
   _____
b) Blood test for thyroid function **YES/NO –** give details and result: _____
c) Ultrasound **YES/NO** - give details and results: _____
d) Laparoscopy **YES/NO** – give details and results: _____
   a. Condition of left fallopian tube: _____
   b. Condition of right fallopian tube: _____
   c. Any adhesions found in the reproductive system? **YES/NO**:_____
   d. Any evidence of endometriosis? **YES/NO**:_____
   e. Any other findings:_____
e) Hysterosalpingogram **YES/NO** or Hy-Co-Sy **YES/NO**: Give details: _____
   _____
   a. Left tube **CLEAR/BLOCKED/PARTIALLY BLOCKED**
   b. Right tube **CLEAR/BLOCKED/PARTIALLY BLOCKED**
f) Hysteroscopy YES/NO Give details and dates: _____

Have you been told you don't ovulate? _____

Have you had any formal infertility specialist diagnosis or other issues? _____

Have you taken any fertility drugs? **YES/NO** give details and dates: _____

_____

Do you have any more treatments planned? **YES/NO** give details and dates: _____

Have you received any other form of treatment for reproductive problems? **YES/NO** Give details:

_____

Other than PCOS, do you suffer from any of the following? If yes, give details and dates of treatment:

a) Pelvic inflammatory disease **YES/NO**:_____
b) Endometriosis **YES/NO**: _____
c) Ovarian Cysts **YES/NO:**_____
d) Fibroids **YES/NO:**_____
e) Candida (thrush) **NO/OCCASIONALLY/FREQUENTLY**
    - Is it vaginal or oral?_____
    - How often do you get it? _____
    - Do you get it with a course of antibiotics? _____
    - When was the last time you had it?_____
f) Genito-urinary infections or cystitis/ bladder infections **YES/NO:** _____
g) Sexually transmitted disease **YES/NO:** _____
h) Cold sores/blisters/warts/herpes **YES/NO:** _____

Have you been tested for antibodies which can cause miscarriage? **YES/NO** give details and results: _____

_____

Have you had a recent Pap Smear? **YES/NO** give result and date: _____

Have you had a cervical erosion/cone biopsy/loop incision/laser treatment/cauterization? **YES/NO** Give details:
_____

Have you ever taken the contraceptive pill? **YES/NO** if yes when? From _____ to _____

Again: _____

Did you suffer any side effects? **YES/NO** Give details: _____

Did you experience any delay in the return of your own cycle once off medication? **YES/NO**, Give details:

_____

Have you had any surgery in the pelvic/abdominal area? **YES/NO** Give details and dates: _____

_____

How would you rate your libido? **STRONG/MODERATE/LOW** Does it increase mid cycle or just prior to your period? _____

Do you experience pain with sex? **YES/NO** if yes give details of where and if it tends to be cycle related or in certain positions. _____

Do you use personal lubricants? **YES/NO** give brand: _____

Maternal Mothers Reproductive history:

How many children did your mother have? _____ Did she have any difficulty conceiving? **YES/NO**
If yes give details: _____

What age did she begin menopause? _____

Female Cycle

How often do you menstruate? How long is your average cycle? _____

How long was your last cycle: _____ What was the date your last period started? _____

What is the longest and shortest cycles you have had: _____

How long do you bleed for? _____ Do you start to bleed straight away or do you spot for a while first? If so, how long do you spot for? _____ What colour is your first blood? _____

Does the colour change throughout the bleed? If so, to what and when:_____

Is your flow **LIGHT/MEDIUM/HEAVY/PROFUSE** If it varies explain how and when: _____

_____

Are there any clots in the blood? **NEVER/OCCASIONALLY/USUALLY/ALWAYS** – How would you describe these clots? **SMALL & STRINGY/SMALL & LUMPY/ LARGE & LUMPY**

Do you spot or bleed any other time of the cycle? **YES/NO** Give details: _____

Menstrual symptoms - circle those applicable and fill in columns

	None/slight/moderate/severe	**Number of days**	**Before/during period**
Abdominal cramps/aching			
Backache			
Nausea/vomiting			
Headaches			
Constipation/diarrhoea			
Skin problems			
Sore breasts			
Fluid retention/bloating			
PMT – moods/tears/anger			
Fatigue			
Food cravings – sugar/choc/other			

Do you need to use any pain medication? **YES/NO** - If so what type and how much? _____

_____

What sort of sanitary items are you using? **CLOTH (reusable) PADS/ORGANIC PADS/OTHER PADS/ORGANIC TAMPONS/OTHER TAMPONS/MENSTRUAL CUP/OTHER DEVICES**

Has there been any recent changes to your cycle? **YES/NO** Give details: _____

_____

Emotions

Emotionally how are you coping with life in general? _____

Describe how you feel about your fertility and the length of time it is taking to conceive: _____

_____

Do you tend to be **ANGRY/FRUSTRATED/DEVASTATED/TEARY/OTHER**: _____

In your own mind do you feel that there is some reason for this delay in conception? Physically, emotionally, spiritually?_____

Is there any past history or emotional event of significants: Physical or sexual abuse, past termination, miscarriage etc?

_____

_____

MALE SECTION

Have you had any of the following fertility investigations? Please email in copies of results.

a) Semen analysis **YES/NO** give details and dates: _____
b) Blood tests **YES/NO** – give dates and type of tests: _____
   _____
c) Thyroid test **YES/NO** details: _____
d) Physical examination or ultrasound of testes **YES/NO** Give details: _____
   a. Any lumps, pain or concerns with your testes? **YES/NO**:_____
   b. Past injuries or operations to the testes? **YES/NO**:_____
   c. Did you have undescended testes as a child? **YES/NO**: was this corrected medically?_____
      _____
e) Have you had any sexually transmitted diseases **YES/NO** if yes, When, what and treatment: _____
      _____
f) Do you have any cold sores/blisters/warts/herpes **YES/NO** details:_____
      _____

Do you exercise wearing **TIGHTS/SYNTHETIC SHORTS/SKINS/LYCRAS/WETSUITS YES/NO**

What type of underwear do you use? Please circle

BOXER/JOCKEY LOOSE/TIGHT FITTED SYNTHETIC/NATURAL FIBRE

Do you use regularly have (please circle) **SAUNAS/SPAS/HOT BATHS YES/NO**

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

Any concerns with your genitalia? lumps, function etc.? **YES/NO: _____**

_____

Have you or do you experience any sexual performance problems or concerns? **ERECTION/EJACTULATION**
Give details of when & what: _____

Have you received any other treatment for reproductive problems? **YES/NO** give details and dates: _____

_____

Have you had any medical procedures, vasectomy/reversal etc.: Y**ES/NO:**_____

How many children did your father have? _____ Did he have any issues with fertility? _____

If Yes give details: _____

Emotions

How do you feel about the time it is taking for your partner to conceive? _____

In your own mind do you feel that there is some reason for this delay in conception? Physically, emotionally, spiritually?_____

Is there any past history or emotional event of significants: Physical or sexual abuse, Past termination or miscarriage etc? _____

_____

MUTUAL FERTILITY

Have you and your current partner undergone a post-coital test? **YES/NO** Give results and date: _____

Have you (female) been tested for sperm antibodies? **YES/NO** Give results and dates: _____

_____

Do you have regular sexual intercourse? **YES/NO -** how often per week would you have sex? _____

Are you using any lubricants? If so, type: _____

Are you aware of the best time in the cycle for conceiving? _____

Are you or your partner away for work commitments or shift work? **YES/NO** If so give details or shifts etc: _____

_____

GENERAL HEALTH - BOTH TO COMPLETE

Female: Height (in cm) _____ Weight (in kg): _____ (Office use) BMI:_____
Male: Height (in cm) _____ Weight (in kg): _____ (Office use) BMI: _____

Do you have regular (at least daily) bowel motions? Female: **YES/NO**: _____Male: **YES/NO: _____**
If not, how often? Female: _____ Male: _____
Do you use laxatives? Female: **YES/NO**: Give details: _____
Male: **YES/NO: _____** Give details: _____
Do you experience constipation/diarrhoea/ flatulence/mucus or blood in stool/heartburn/indigestion/bloating/bad breath? Female: **YES/NO**: _____ Give details: _____
Male: **YES/NO: _____** Give details: _____

Do you have or have ever had an eating disorder? If yes, who, what & when: _____

_____

Do you experience food cravings? Female: **YES/NO**: Give details: _____

Male: **YES/NO:** Give details: _____

Do you suffer from headaches? Female: **YES/NO**: Give details: _____

Male: **YES/NO:** Give details: _____

Do you consider yourself stressed? Female: **YES/NO**: Give details: _____

Male: **YES/NO:** Give details: _____

Do you sleep well? How many hours undisturbed would you get each night?

- Female: **YES/NO**: Give details: _____
- Male: **YES/NO:** Give details: _____
- Are you still tired on waking? Female: **YES/NO**: Give details: _____
- Male: **YES/NO:** Give details: _____

How do you rate your energy levels? Female: **LOW/MED/HIGH** Male: **LOW/MED/HIGH**

How often in the 12 months did you suffer with a cold/infection/flu etc? Female: **NEVER/0-2/3-5/5-10 TIMES** Male: **NEVER/0-2/3-5/5-10 TIMES**

Do you have any allergies or sensitivities? (hay fever/food sensitivities etc.)

Female: **YES/NO**: _____ Give details: _____
Male: **YES/NO: _____** Give details: _____

Do you follow any particular eating plan/diet? Who?

GLUTEN FREE/LACTOSE FREE/ VEGAN/VEGETARIAN/ORGANIC/OTHER: _____

_____

How often would you consume red meat in your diet? Female: **NEVER/1-2 MONTH/1-2 WEEK/DAILY**

Male: **NEVER/1-2 MONTH/1-2 WEEK/DAILY**

Do you tend to watch the amount of fat in your diet? Do you choose low-fat choices? Give details:

Female: _____ Male: _____

How many pieces of fruit do you eat each day?

Female: **None/Rarely/1 Daily/2 or more daily**

Male: **None/Rarely/1 Daily/2 or more daily**

How many different types of vegetable would you eat each day (other than standard white potato or peas)?

Female: **None/Rarely/1-3 Daily/4 or more daily**

Male: **None/Rarely/1-3 Daily/4 or more daily**

Do you suffer (recently or significantly) from any of the following? (Please tick)

	Female	**Male**		**Female**	**Male**		**Female**	**Male**
Anxiety			Depression			Mouth ulcers		
Arthritis			Dermatitis/eczema			Nasal/sinus congestion		
Asthma			Dizziness			Numbness/tingling		
Back pain Lower			Ear infections			Panic attacks		
Bleeding gums			Forgetfulness			Sensitivity to light/noise		
Brittle nails			Hair loss (not male balding)			Sensitivity to odours		
Easy Bruising			Irritability			Skin problems/ rashes/other		
Cod hand/feet			Irritable bowel			Sweating (excess/night)		
Confusion			Itchiness			tinnitus		
Cramps			Joint/muscle pain			Varicose veins		

Do you do any exercise? Give details of type, frequency, intensity, time etc:

Female: **YES/NO:** _____

Male: **YES/NO:** _____

ADDITIONAL NOTES/INFORMATION – attach separate sheet if needed

Please supply copies of blood tests, semen analysis or other investigative report if you have them available.