



# Natural Fertility Management

## CONTRACEPTION PROGRAM QUESTIONNAIRE

Please answer each question, with full details and dates. All information is strictly confidential.

DATE OF CONSULTATION \_\_\_\_\_

HOW DID YOU HEAR OF THIS PRACTICE? \_\_\_\_\_

\_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ BIRTH TIME \_\_\_\_\_ BIRTH PLACE \_\_\_\_\_  
*Please use 24 hour clock eg: 3.00pm is 15:00pm*

OCCUPATION (please list specific activities) \_\_\_\_\_

\_\_\_\_\_

PHONE NO WORK (\_\_\_\_) \_\_\_\_\_ HOME (\_\_\_\_) \_\_\_\_\_ MOB (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

EMAIL \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

GENERAL PRACTITIONER \_\_\_\_\_

IF CURRENTLY SEEING A GYNAECOLOGIST / SPECIALIST, NATURAL THERAPIST OR OTHER PRACTITIONER

(1) NAME \_\_\_\_\_

(1) PHONE \_\_\_\_\_

(2) NAME \_\_\_\_\_

(2) PHONE \_\_\_\_\_

(3) NAME \_\_\_\_\_

(3) PHONE \_\_\_\_\_

OFFICE USE ONLY			
KIT	OTHER	RESULT	END OF TREATMENT

Have you previously received a Natural Fertility Management Kit? **YES / NO** If so, from whom? \_\_\_\_\_

Was naturopathic advice included? **YES / NO**

## **REPRODUCTIVE HEALTH**

What are you using for contraception at the moment? \_\_\_\_\_

How long have you been using this method? \_\_\_\_\_

Have you ever taken the oral contraceptive pill? **YES / NO** If Yes, when? From \_\_\_\_\_ to \_\_\_\_\_

Did you suffer any side effects? **YES / NO** If so, give details \_\_\_\_\_

Did you experience delay in your cycle returning? **YES / NO** If so, give details \_\_\_\_\_

Have you used condoms? **YES / NO** If so, was the experience successful? Give details \_\_\_\_\_

Have you used a diaphragm? **YES / NO** If so, was the experience successful? Give details \_\_\_\_\_

Have you ever used IUD? **YES / NO** If yes, when? From \_\_\_\_\_ to \_\_\_\_\_

Did you experience any problems? **YES / NO** If yes, give details and dates \_\_\_\_\_

Have you charted your basal (body at rest) temperature? **YES / NO** Give dates \_\_\_\_\_

Were you taking fertility drugs? **YES / NO**

Do your charts show a mid-cycle rise? **NEVER / SOMETIMES / USUALLY / ALWAYS**

On which day(s) of cycle (on average) does the temperature rise? \_\_\_\_\_

Have you charted your cervical mucus changes? **YES / NO**

Do you look for cervical mucus changes? **NEVER / SOMETIMES / USUALLY / ALWAYS**

Does your mucus change mid-cycle? **NEVER / SOMETIMES / USUALLY / ALWAYS**

On which days do you experience fertile mucus? \_\_\_\_\_ Has your cervical mucus ever been tested? **YES / NO**

Give results and dates: Amount \_\_\_\_\_ pH \_\_\_\_\_ Ferning **YES / NO** Cervical Score \_\_\_\_\_

Have you, or do you, suffer from any of the following? *(If yes, also give dates and details of treatment)*

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) **NO / OCCASIONALLY / FREQUENTLY** \_\_\_\_\_

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

What makes it worse? \_\_\_\_\_

How often have you suffered from Candida in the last year? \_\_\_\_\_

Other genito-urinary infections or sexually transmitted diseases (including cystitis) **YES / NO** \_\_\_\_\_

Herpes / Blisters / Warts (specify which) **YES / NO** \_\_\_\_\_

Abnormal Pap Smear **YES / NO** \_\_\_\_\_

Cervical erosion / biopsy / laser treatment / cauterisation **YES / NO** \_\_\_\_\_

Have you had any conceptions? **YES / NO** Specify whether birth / miscarriage / termination with dates and details of any complications \_\_\_\_\_

### **GENERAL HEALTH**

Have you ever suffered from any of these conditions? (If yes, give dates and details)

Liver disease **YES / NO** Give details \_\_\_\_\_

Cardio-vascular disease (Including abnormal blood pressure, high cholesterol, poor circulation, angina, palpitations)

**YES / NO** Give details \_\_\_\_\_

Mental/ Nervous system disease **YES / NO** Give details \_\_\_\_\_

Glandular fever/ chronic fatigue **YES / NO** Give details \_\_\_\_\_

Other major diseases / conditions **YES / NO** Give details \_\_\_\_\_

Do you have any allergies or sensitivities? **YES / NO** Give details \_\_\_\_\_

Do you have any food cravings? **YES / NO** If so, is this for sugar / chocolate / carbohydrates? \_\_\_\_\_

How often in the last year have you suffered from infections/colds / flu etc.? **NEVER / OCCASIONALLY / FREQUENTLY**

Do you have regular (at least once daily) bowel motions? **YES / NO** Give details \_\_\_\_\_

If not, how often do you have a bowel motion in a typical week? \_\_\_\_\_

Do you use laxatives? **YES / NO** Give details \_\_\_\_\_

Do you experience constipation / diarrhoea / flatulence / mucus or blood in stools / heartburn / indigestion / bloating / bad breath? **YES / NO** Give details \_\_\_\_\_

Do you have any malabsorption / eating disorders? **YES / NO** (Give details \_\_\_\_\_)

Do you suffer from headaches? **YES / NO** Give details \_\_\_\_\_

Do you consider yourself stressed? **YES / NO** Give details \_\_\_\_\_

Do you sleep well? **YES / NO** Give details \_\_\_\_\_

Are you tired on waking? **YES/NO** Give Details \_\_\_\_\_

How do you rate your energy levels? **LOW / MEDIUM / HIGH**

Do you smoke cigarettes? **YES / NO** Give details \_\_\_\_\_

Do you use any recreational drugs (including alcohol?) **YES / NO** Give details \_\_\_\_\_

Are you taking any medication? **YES / NO** Give details \_\_\_\_\_

Are you taking any dietary supplements? **YES / NO** Give details and dosages. Please do not use brand names \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CYCLE DETAILS**

How often do you menstruate? Normal average length of cycle is \_\_\_\_\_ days.

If this varies, give shortest cycle usually experienced \_\_\_\_\_ days, and longest cycle usually experienced \_\_\_\_\_ days.

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

Is the flow **HEAVY / MEDIUM / LIGHT ?**

Is the blood **BRIGHT / DARK ?**

Are there clots in the blood? **NEVER / OCCASIONALLY / USUALLY / ALWAYS**

How would you describe these clots? **SMALL & STRINGY / SMALL & LUMPY / LARGE & LUMPY**

Do you experience spotting before your period starts? **YES / NO** If so, for how many days? \_\_\_\_\_

Do you experience mid-cycle spotting? **YES / NO** Please give details \_\_\_\_\_

Do you experience mid-cycle pain? **YES/NO** Please give details \_\_\_\_\_

Do you use **CLOTH (REUSABLE) PADS / OTHER PADS / ORGANIC TAMPONS / OTHER TAMPONS?** (please circle)

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

	<i>None / Slight / Moderate / Severe</i>	<i>Number of Days</i>	<i>Before / During Period</i>
Abdominal cramping/aching (specify which)			
Backache			
Nausea/Vomiting (specify which)			
Headaches			
Constipation/Diarrhoea (specify which)			
Skin problems			
Sore breasts			
Fluid retention			
PMT			
Fatigue			
Food cravings (specify eg sugar/chocolate)			

Do you need to take pain killers? **NEVER / SOMETIMES / USUALLY / ALWAYS**

If so, for how many days before/during your period? \_\_\_\_\_

Have there been any recent changes in your cycle? **YES / NO** Give details \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL INFORMATION**

(Please use other side if needed)

**ADDITIONAL INFORMATION (CONT)**