Health Appraisal Questionnaire
Female Fertility

Name: ________________________________ DOB: _____________

Address: ____

____

Phone: _____________ Mob: _____________Email:_____________

Include the name and number of the following contacts if applicable:

GP: ____

Gynecologist: ____

Obstetrician: ____

IVF Specialist: ____

Your Signature: ____

Please read each question below carefully and thoroughly and provide a detailed and truthful answer. Please complete this questionnaire & return it to us <u>as soon as possible</u>.

Note: All information is regarded as strictly confidential and governed under the code of ethics.

Medical History:

1. Have you ever had serial blood work done for any of the following (please circle):

Karyotyping	Hormone assay	Thyroid function	HIV
Full blood analysis	Fasting glucose	Cholesterol	
Hepatitis C	STIs	Cystic Fibrosis Screening	

If you circled any of the above, when was the testing carried out, what were the results? ____

____

2. Do you have/have you suffered from any of the following medically diagnosed conditions (please circle):

   High blood pressure   High cholesterol   Diabetes   An STI

   Other ____

   If you circled any of the above, please provide details: ______________________

   ____

General History:

3. How long have you been trying to conceive? ______________________

4. What other methods, if any, have you tried to assist you to conceive:

   Natural methods:

   Temperature charting? Y / N

   Other ____

   Assisted Fertility (please circle if any applicable):

   IVF   IUI   ICSI   Chlomid Cycle   FT

   If you circled any of the above

   How many cycles? ______________

   When did you begin the treatment/cycles? __________________

   When was your most recent treatment/cycle? ______________

   Any other relevant details ______________________________

5. Have you been medically diagnosed with any of the following (please circle)?

Endometriosis   Ovarian Cycsts   Uterine fibroids

PCOS   Pelvic adhesions/masses   CIN

Other ____

6. Have you had any of the following medical procedures done (please circle)?

Laparoscopy	Dye studies	Hysteroscopy	TVG
Endometrial Biopsy	Ultrasound	NK cell studies	HSG
LETZ	Lone Biopsy	Other ________________________	

If you circled any of the above, when was the procedure done and where? ______

____

____

7. Have you had any of the following abdominal/pelvic procedures done (please circle):

Hernia Appendix Laparotomy C-Section

Other ____

If you circled any of the above, when was the procedure done? ______________

8. Have you ever had a termination? Y / N

If yes, how many and when? ____

9. Have you ever had a miscarriage? Y / N

If yes, how many and when? ____

10. Are you taking any medication at all whatsoever? Please be specific and include any vitamins and herbal supplements. _____________________________________

____

11. How many times per week are you currently having sex? ___________________

12. Do you feel that you are having sex as regularly as you should be? If not, please explain why. ____

____

13. Are there any known issues with sperm count, motility, morphology etc? _______

____

14. Has your partner had a recent Comprehensive Semen Analysis? Y / N

If yes, where was the test conducted (circle): a pathology lab fertility clinic

When was the test done (circle): last 3 months last 6 months 6 months+

Menstrual History

15. Are you currently getting a cycle? Y / N
16. Is your cycle regular? Y / N
17. How many days is your cycle (e.g. 28 -30 days)? ______________________________
18. How many days does your menstrual flow last? ______________________________
19. Do you get any clots in the menstrual flow? If so, are there many and how big?

____

20. Do you get any dark coloured or brown menstrual flow?

____

21. Do you get any pain or cramps:

		Pain Rating (1-10)
Before your period?	Y / N	_____________
During your period?	Y / N	_____________
After your period?	Y / N	_____________
Mid cycle?	Y / N	_____________

Note: where you circled yes, please rate the severity of the pain where 1 is very mild and 10 is very strong.

22. Do you experience any of the emotions below with your period (tick the applicable):

☐ Teariness	☐ Flat	☐ Frustration
☐ Irritability	☐ Anger	☐ Cold
☐ Tired	Other ___________________________	

23. Do you experience any breast tenderness:

Before your period? Y / N

During your period? Y / N

After your period? Y / N

Mid cycle? Y / N

24. Do you experience any bloating or fluid retention:

    Before your period? Y / N

    During your period? Y / N

    After your period? Y / N

    Mid cycle? Y / N

25. Are there any changes to your appetite before, during or after your period? Y / N

    If yes, Please describe (include cravings) ________________________________

    ____

26. Do your bowel habits change with the onset of your period? Y / N

    If yes, Please describe____

27. Do you experience any headaches during your period? Y / N Mid cycle? Y / N

    If yes, Please describe____

28. Do you experience any bleeding mid cycle? Y / N

29. Do you experience any discharge mid cycle? Y / N

Diet

30. Please complete the table on the following page including a detailed description of what you would eat at each meal on a typical day:

Breakfast	
Morning Tea	

Lunch	
Afternoon Tea	
Dinner	
Dessert	
Any other snacks	
Approximate water intake plus other beverages	

31. How many standard glasses of alcohol do you drink per week? ________________

32. Do you drink alcohol daily or only on weekends? ____________________________

33. How many cups of tea/coffee do you drink per day? _________________________

34. Do you drink any caffeinated soft drinks? __________________________________

Appetite / Digestion

35. How is your appetite (circle): Low Average High

36. How is your digestion (circle): Good Fluctuates Bad

37. Do you get any sugar cravings? Y / N If yes, when? ____________________

38. Do you get any of the following (circle): Bloating Burping

Wind Heartburn Nausea Other _____________

If you circled any of the above how often and when? _________________________

39. Do you often skip meals? ____

Bowels

40. How many times per day do you move your bowels? ________________________

41. Are your motions (circle): Loose Normal Hard Alternating

42. Do you suffer from either lose bowels or constipation often? _________________

____

43. Are your bowel habits effected by stress? Y / N

Emotions

44. Please tick any of the following emotions if you feel that they would describe you:

☐ Worry a lot ☐ Quick to anger ☐ Often irritable

☐ Sometimes feel depressed ☐ Feel resentful ☐ Feel frustrated

☐ Sad ☐ Fearful in general ☐ Think a lot

☐ Stressed, hard to relax ☐ Anxious ☐ Panicky

☐ 'Fuzzy' in the head ☐ Burnt out/ tired

☐ Other ____

Sleep

45. Do you sleep well? Y / N

46. Do you have a medically diagnosed sleep condition? Y / N _________________

47. Do you snore? Y / N

48. Do you wake feeling refreshed? Y / N

49. Do you find it hard to get to sleep? Y / N

50. Do you have vivid dreams? Y / N

51. Do you wake a lot during the night? Y / N If yes, how many times? _________

52. Do you experience nocturnal urination? Y / N

If yes, how many times per night? ________

Miscellaneous

53. Do you smoke (includes social smoking)? Y / N If yes, how often? _________

54. Do you currently or have you ever used recreational drugs? Y / N

    If yes, when and what (please be specific) _________________________________

55. Do you suffer from the following (please circle): Headaches Migraines

    Back pain Stiff/Sore neck Stiff/sore shoulders

    Any other conditions not mentioned above: _______________________________