NICOLE TRICARICO

Support and Solutions for Health and Wellbeing

Naturopath~Natural Fertility Counsellor~Birth Story Healer
116 Corio Street, Shepparton VIC 3630
Phone: (03) 58 31 5400
Email: naturopathnicole@gmail.com

FERTILITY INFORMATION SHEET

Please answer each question, for both partners wherever possible, with full details and dates. All information is strictly confidential.

Date of first consultation................... How did you hear of this practice?...

Name (Female)... (Male)...

Address...

....Post code.......................

Phone: (Daytime).......................... (After hours)................................
(Mobile)...

Age (Female)............. Birth date................. Birth time................ Birth
place...

Age (Male)................ Birth date................. Birth time............... Birth place..

Please use 24 hour clock when giving birth time. E.g. 3 minutes past midnight is 00:03am, 3.00pm is 15:00pm If

currently seeing a GP, gynaecologist, natural therapist, or NFM practitioner, provide name and

phone numbers:..

Have you previously received a Natural Fertility Management Kit? **YES / NO**

If so, from
whom?...

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

Have you previously sent this practice any information/results? **YES / NO**

LIFESTYLE / ENVIRONMENT

What is your occupation? (Please list specific activities)

(Female)...

(Male)...

Hobbies and other activities:

(Female)...

(Male)...

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Do any of these activities involve contact with chemicals/ heavy metals/ other toxins? (Give details)

(Female) **YES / NO**...

(Male) **YES / NO**...

Have you had any X-rays done in the last 5 years? (Give approximate dates)

(Female) **YES / NO**...

(Male) **YES / NO**...

Do you use a computer? If so, for how many hours daily?

(Female) **YES / NO**...

(Male) **YES / NO**...

How often do you fly?

(Female)...

(Male)...

	FEMALE YES / NO	**MALE YES / NO**
Do you regularly use a mobile phone?		
Do you sleep near a fuse box?		
Do you live / work near a transmitter?		
Do you have electrical appliances in your bedroom?		
Do you live / work near a major road / flight path?		
Do you regularly travel in rush hour / busy traffic?		
Do you use chemical cleansers or insecticides?		
Have you recently conducted any renovations / pest control? If so, please give details:		

Do you smoke cigarettes? If so, how many per day?

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(Female)...
(Male)..

Do you use any recreational drugs (including alcohol)? Give details, including amount and how often.

(Female) **YES / NO**...

(Male) **YES / NO**...

REPRODUCTIVE HEALTH

Have you already started trying to conceive? **YES / NO** If so, when did you start?......................................

Have you had any previous conceptions? (female) **YES / NO**

If yes, specify whether live birth / miscarriage / termination / premature / small for dates / prenatal death with date sand details of any complications and how long it took / any difficulties conceiving previously?...

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

Has your current partner been responsible for any conceptions other than those specified above?

YES / NO Give details as above...

....

FEMALES

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

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

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

If so, on which day/s of the cycle (on average)..

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

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

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

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On which days do you experience fertile mucus?..

Has your cervical mucus ever been tested? **YES / NO**

If so, results and dates: Amount.................. pH................... Ferning YES / NO............... Score...................

Have you previously has any medical fertility investigations? (any further tests required can be recommended after consultation) **YES / NO**

a) Blood tests to show hormone levels? **YES / NO** If so, give results (normal/elevated/deficient) of each hormone tested, dates and day of cycle:

Oestrogen .... Progesterone .... LH ....

Prolactin...................................... Testosterone .... FSH ....

b) Blood tests for thyroid function? **YES / NO** If so, give results and dates (normal/elevated/deficient)..

c) Ultrasound? **YES / NO** If so, give results and dates...

d) Laparoscopy? **YES / NO** If so, give results and dates...

Present condition of left tube: **CLEAR / BLOCKED / SCARRED / ADHERED** Present condition of right tube: **CLEAR / BLOCKED / SCARRED / ADHERED**

Are there adhesions to any other part of the reproductive system? **YES / NO**

Is there any evidence of endometriosis? **YES / NO**

Any other information?...

e) Hysterosalpingogram? **YES / NO**

If so, give results and dates...

Left tube: **CLEAR / BLOCKED / SCARRED / ADHERED**

Right tube: **CLEAR / BLOCKED / SCARRED / ADHERED**

f) Hysteroscopy? **YES / NO** If so, give results and dates...

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Have you taken any fertility medication? **YES / NO** If so, give details and dates..

....

Have you undergone treatment on an assisted conception programme? **YES / NO**

If so, give details and dates..

Do you have any more treatment planned? **YES / NO**

If so, give details and dates..

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

If so, give details and dates..

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

Pelvic Inflammatory Disease	**YES / NO**	....
Endometriosis	**YES / NO**	....
Polycystic Ovarian Syndrome	**YES / NO**	....
Ovarian Cysts	**YES / NO**	....
Fibroids	**YES / NO**	....
Candida (Thrush)	**YES / NO**	OCCASIONALLY / FREQUENTLY Vaginal or Systemic?.. How severe?... What makes it worse?.. How often have you suffered from Candida in the last year?.. ....
Genito-Urinary Infections or sexually transmitted diseases (including cystitis)	**YES / NO**	Give details and dates.. ....
Herpes/Blisters/Warts (specify which)	**YES / NO**	Give details and dates.. ....

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Have you had a recent Pap Smear? **YES / NO** If so, gives details and dates...

Have you had a cervical erosion/cone biopsy/laser treatment/cauterizations? **YES / NO**

If so, give details and dates...

Have you ever taken the contraceptive pill? **YES / NO** If yes, when? From..................... To.......................

Did you suffer any side effects while on the pill? **YES / NO** Give details..

Did you experience any delay in the return of your cycle once coming off the pill? **YES / NO**

If so, give details...

Have you ever used an IUD? **YES / NO** If yes, when? From.......................... To.............................

Did you experience any problems with the IUD? **YES / NO**

If so, give details and dates...

Have you had any surgery in the pelvic/abdominal area? **YES / NO**

If so, give details and dates...

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

MALES

Have you previously had any medical fertility investigations? **YES / NO**

a) Semen analysis? **YES / NO** (Give details and dates)

Count..................................million/mL pH... Vol..mL

Motility........................% Progressive motility.......................% Are antibodies/clumping present? **YES / NO**

Morphology (give % of normal sperm)..

b) Blood tests for hormonal levels? **YES / NO** Give result (normal/elevated/deficient) of each hormone tested and dates:

Testosterone.. FSH... LH...

c) Blood tests for thyroid function? **YES / NO** If so, give results and dates

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(normal/elevated/deficient)..

d) Have you been examined for a varicocele? **YES / NO** Give details and dates..

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

Condition		Details
Undescended testes/testicular disease/vasectomy	**YES / NO**	....
Mumps	**YES / NO**	....
Genito-Urinary Infections or sexually transmitted diseases (including cystitis)	**YES / NO**	....
Herpes/Blisters/Warts (specify which)	**YES / NO**	Give details and dates.. ....

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

Give dates and details...

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

MUTUAL FERTILITY

Have you and your current partner undergone a post-coital test? **YES / NO**

Give results and dates...

Have you undergone a post-coital test with a different partner? **YES / NO**

Give results and dates...

Have you and your current partner undergone a sperm/cervical mucus contact test? **YES / NO**

If so, give results and dates (including cross-match with donor sperm/mucus)...

....

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GENERAL HEALTH

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

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

(Female) **YES / NO**..

(Male) **YES / NO**...

b) Liver disease?

(Female) **YES / NO**..

(Male) **YES / NO**...

c) Mental/Nervous system disease?

(Female) **YES / NO**..

(Male) **YES / NO**...

d) Glandular fever/Chronic fatigue?

(Female) **YES / NO**..

(Male) **YES / NO**...

Do you have regular (at least daily) bowel motions? (Female) **YES / NO** (Male) **YES / NO** If not, how often do you have a bowel motion in a typical week?

(Female)... (Male)...

Do you use laxatives? If so, give details

(Female) **YES / NO**..

(Male) **YES / NO**...

(Female) Do you experience constipation/diarrhoea/flatulence/mucus or blood in stools / heartburn / indigestion/bloating/bad breath? Give details...

....

(Male) Do you experience constipation/diarrhoea/flatulence/mucus or blood in stools/heartburn/indigestion/bloating/bad breath? Give details...

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Do you have any malabsorption/eating disorders? Give details

(Female) **YES / NO**..

(Male**)** **YES / NO**..

Do you suffer headaches? How often? Give details

(Female) **YES / NO**..

(Male**)** **YES / NO**..

Do you consider yourself stressed? Give details

(Female) **YES / NO**..

(Male) **YES / NO**...

Do you sleep well? Give details

(Female) **YES / NO**..

(Male) **YES / NO**..

Are you tired on waking? Give details

(Female) **YES /**
NO...

(Male) **YES / NO**..

How do you rate your energy levels? Give details

(Female) **YES / NO**..

(Male) **YES / NO**..

How often in the last year have you suffered from infections/colds/flu etc?

(Female) **NEVER / OCCASIONALLY / FREQUENTLY**

(Male) **NEVER / OCCASIONALLY / FREQUENTLY**

Do you have any allergies or sensitivities? Give details.

(Female) **YES / NO**..

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(Male) **YES / NO**..

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

	F	M		F	M		F	M
Arthritis			Dizziness			Mouth ulcers		
Asthma			Ear infections			Nasal/sinus congestion		
Back pain			Food cravings			Numbness/tingling		
Bleeding gums			Forgetfulness			Palpitations		
Brittle nails			Hair loss			Panic attacks		
Bruising			Hay fever			Sensitivity to light/noise		
Cold hands/feet			Irritability			Sensitivity to odours		
Confusion			Irritable bowel			Skin problems/rashes		
Cramps			Itchiness			Sweating (excess)(night)		
Depression			Joint/muscle pain			Tinnitus		
Dermatitis/eczema			Migraine			Varicose veins		

Are you taking any medication? Give details

(Female) **YES / NO**...

(Male) **YES / NO**..

Are you taking any dietary supplements? Give details (If attending personally, please bring along all containers. Postal clients, give details and total dosage of each nutrient and brand names)

(Female) **YES / NO**...

(Male) **YES / NO**..

Who prescribed these supplements?

(Female).. (Male)..

CYCLE DETAILS

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

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If this varies, shortest cycle usually experienced is.............................. days, and longest usually experienced is .... 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** Give details...

Do you experience mid-cycle pain? **YES / NO** Give details...

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

	NONE/SLIGHT/MODERATE SERVERE	NUMBER OF DAYS	BEFORE /DURING PERIOD
Abdominal cramping			
Backache			
Nausea/Vomiting (specify which)			
Headaches			
Constipation/diarrhoea (specify which)			
Skin problems			
Sore breasts			
Fluid retention			
PMT			
Fatigue			
Food cravings			

If you experience food cravings, what foods are these for?..

If you crave sugar, is this principally for chocolate?...

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

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

Have there been any recent changes in your cycle? **YES / NO**

If yes, give details...

* Once complete email back to naturopathnicole@gmail.com or bring to your appointment

ADDITIONAL INFORMATION

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