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**Reproductive Reflexology**

**Pre-Conceptual Questionnaire**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*All the information in this document is treated in strictest confidence*

*and will not be divulged to anyone, without your permission.*

**Female** **Male**

Name…………………………………………………………………………………... Name…………………………………………………………………………………

Address………………………………………………………………………………… Address……………………………………………………………………………..

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Tel………………………………………………………………………………………… Tel……………………………………………………………………………………..

Email……………………………………………………………………………………. Email………………………………………………………………………………….

Age……………………………….…….. DOB……………………………… Age……………………………………. DOB………………………………

Occupation............................................................................... Occupation............................................................................

Hobbies.................................................................................... Hobbies.................................................................................

Height................................ Weight..................................... Height............................ Weight.....................................

BMI.................... BMI.....................

**GP Name**.................................................................................. **GP** **Name**...............................................................................

Address.................................................................................... Address.................................................................................

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Tel............................................................................................ Tel.........................................................................................

**Fertility Clinic and Consultant (if applicable)**

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**Fertility Difficulties**

**Female**....................................................................................... **Male**.............................................................................................

Number of Years.................................. Number of Years..................................

**Previous Treatments** CLOMID/MED CYCLE Y/N IUI Y/N IVF/ICSI Y/N

**Female Gynaecological History Male Fertility Status**

Do you have or have you suffered from any of the following? Have you had a semen analysis? Y/N

*(Please tick any that apply, either currently or previously)* Dates..........................................................................................

Amenorrhoea (no periods) Irregular periods Count (in millions)......................................................................

Anovulation Low back pain % normally formed sperm.........................................................

Malformed womb Ovulation pain % motile sperm..........................................................................

Cystitis Ovarian Cysts \*\*IF SO, PLEASE PROVIDE A COPY IF POSSIBLE\*\*

Endometriosis Andometriosis

Fallopian tube issues Pain on intercourse **Have you had any of the following?**  (Please tick any that apply)

Painful periods PMS Mumps Testicular cancer

Thrush Fibroids Non-specific urethritis Varicocele

Genital ulcers Water retention Rubella Vasectomy reversal

Vaginal discharge/burning/irritation Thyroid problems

**FEMALE MALE**

Have you been checked or previously treated for: Have you been checked or previously treated for:

AIDS Candida AIDS Chlamydia

Gonorrhoea Cervical Erosion Gonorrhoea Syphilis

Strep B Chlamydia Herpes Genital Warts

Herpes Genital Warts Candida Trichomonas

Syphilis Trichomonas Chlamydia

**Contraception**

For how long?............................................................................. Dates..................................................................................

*(Please tick which of the following apply)*

Coil OCP Diaphragm Condom

Female Condom Sponge Natural Family Planning Persona

None Other....................................

**Female** **Male**

**Current Medical Treatments** *(Please tick any that apply)* **Current Medical Treatments** *(Please tick any that apply)*

Antidepressants Painkillers Antidepressants Painkillers

Diuretics Sleeping Tablets Diuretics Sleeping Tablets

Steroids Laxatives Steroids Laxatives

Tranquillizers Thyroxine Tranquillisers Thyroxine

 Anti-Convulsants Beta-Blockers

**Any further information about present/past fertility issues? Any further information about present/past fertility issues?**

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**Other medication/supplements** **Other medication/supplements**

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**Female** **Male**

Do you smoke? Y/N How many per week?........................ Do you smoke? Y/N How many per week?......................

Do you drink? Y/N How many units per week?............... Do you drink? Y/N How many units per week?..............

Do you use drugs? Y/N Please provide further info............... Do you use drugs? Y/N Please provide further info.............

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**Thank you for providing this information. Please be reassured that it will be treated with the greatest confidence, and will only be used in helping you to achieve your goal of conception and parenthood.**

**Please email this form, along with any other test results/semen analysis, etc. to me at** **jo@barefoot-reflexology.co.uk** **before your initial consultation.**

**(For women, if you haven’t already started, please consider temperature-charting. It will provide invaluable information).**

**(For men, if you haven’t already done so, please consider asking your GP for a semen analysis. Again, the information it will provide is invaluable).**