

FEMALE PREVIOUS REPRODUCTIVE HISTORY

Previous children:

Sex	Birthweight	Year
1.....
2.....
3.....

Problems in Pregnancy/Birth – details (how many etc.):

Perinatal Death(s).....	Dates:.....
Miscarriage(s).....	Dates:.....
Premature Birth(s).....	Dates:.....
Therapeutic Termination(s).....	Dates:.....
Stillbirth(s):.....	Dates:.....
SIDS (Sudden Infant Death):.....	Dates:.....
Small Baby's (at term):.....	Dates:.....
Malformation(s) <i>please provide details</i>	

Other problems during Pregnancy?

Lactation, e.g. how long? Any problems? *Please provide details:*

Allergic illness & other health problems in children?

INFERTILITY Details: Years.....

Female Male

Previous Fertility treatments – Success Y/N

IVF IUI ICSI

Consultant..... Clinic

Please return your completed form and hair sample(s) to:

3 Lower Queens Road, Clevedon, N Somerset BS21 6LX
Tel. 01275 878953 e: info@foresight-preconception.org.uk



FORESIGHT

PRECONCEPTION QUESTIONNAIRE

Date: Ref. No.

All information in this document will be treated in strictest confidence.

FEMALE PARTNER

MALE PARTNER

Name:

Name:

Address:.....

Address (if different).....

Email:

Email:.....

Tel. No(s):.....

Tel. No(s):

Occupation:.....

Occupation:.....

Age:..... DOB:.....

Age:..... DOB:.....

Ethnic origin:.....

Ethnic Origin:

Height (m)

Height (m)

Weight (kg).....

Weight (kg)

Foresight Practitioner details:.....

SPECIFIC INFORMATION FOR THIS HAIR SAMPLE(S): Please give details for male and female as these can affect results*

Bleach/colouring

Perm

Shampoo (brand)

Conditioner (brand)

**Please refer to hair test form for details – permanent hair dyes can produce a less accurate result*

FEMALE GYNAECOLOGICAL HISTORY

DO/DID YOU SUFFER FROM ANY OF THE FOLLOWING:

Please tick box

	Do	Did		Do	Did
Amenorrhoea (no periods)	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Anovulation	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps (benign)	<input type="checkbox"/>	<input type="checkbox"/>	Malformed womb	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ovulation Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cystitis	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Pain on intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Fallopian Tubes:			Painful periods	<input type="checkbox"/>	<input type="checkbox"/>
Blocked <input type="checkbox"/>	Malformed		PMS	<input type="checkbox"/>	<input type="checkbox"/>
Removed <input type="checkbox"/>	Twisted		Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids			Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Frequency (of urine)			Vaginal burning	<input type="checkbox"/>	<input type="checkbox"/>
Genital ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Water Retention	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU BEEN CHECKED/IF POSITIVE, TREATED FOR:

HIV/Aids	<input type="checkbox"/>	Gonorrhoea	<input type="checkbox"/>
Anaerobic bacteria	<input type="checkbox"/>	Haem. Influenza	<input type="checkbox"/>
B. Strep	<input type="checkbox"/>	Haem. Strep	<input type="checkbox"/>
Blocked tubes	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
Cervical erosion	<input type="checkbox"/>	Klebsiella	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	Mycoplasma	<input type="checkbox"/>
Cytomegalovirus	<input type="checkbox"/>	Staph. Aureus	<input type="checkbox"/>
Enterococcus	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
E. Coli	<input type="checkbox"/>	Trachimonas	<input type="checkbox"/>
Gardnerella	<input type="checkbox"/>	Ureaplasma	<input type="checkbox"/>
Genital Warts	<input type="checkbox"/>	Toxoplasmosis	<input type="checkbox"/>

ANY FURTHER INFORMATION ABOUT PRESENT/PAST INFERTILITY

TREATMENT:

.....

.....

FERTILITY DRUGS e.g Clomid, Danazol, Heparin, Aspiring – details:

.....

.....

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CONTRACEPTION

How long?Dates.....

	No. of years		No. of years
Coil	<input type="checkbox"/>	Pill	<input type="checkbox"/>
Diaphragm	<input type="checkbox"/>	Sheath/condom	<input type="checkbox"/>
Female Condom	<input type="checkbox"/>	Sponge	<input type="checkbox"/>
Natural Family Planning	<input type="checkbox"/>	None	<input type="checkbox"/>
Persona	<input type="checkbox"/>		

HAVE YOU BEEN IMMUNIZED FOR RUBELLA?

When? When checked?

MALE FERTILITY STATUS

Please tick box:

Have you had a sperm count?
 If so, Number (million)

Percentage of Malformed sperm

Percentage of Immotile sperm

Clumping?

IN THE PAST HAVE YOU HAD:

Mumps	<input type="checkbox"/>	Testicular cancer	<input type="checkbox"/>
Non specific urethritis	<input type="checkbox"/>	Varicoceal	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	Vasectomy reversal	<input type="checkbox"/>

HAVE YOU BEEN CHECKED/IF POSITIVE TREATED FOR?

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B. Strep	<input type="checkbox"/>	Haem. Strep	<input type="checkbox"/>
Blocked tubes	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
Cervical erosion	<input type="checkbox"/>	Klebsiella	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	Mycoplasma	<input type="checkbox"/>
Cytomegalovirus	<input type="checkbox"/>	Staph. Aureus	<input type="checkbox"/>
Enterococcus	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
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DEFICIENCY SYMPTOMS:

Please tick box in the Female (F) or Male (M) boxes

	F	M		F	M
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Grooved Tongue	<input type="checkbox"/>	<input type="checkbox"/>
Apathy	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Halitosis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Body odour	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	Lank hair	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Catarrh	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	Short sight	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Stretch marks	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Sweating (heavy)	<input type="checkbox"/>	<input type="checkbox"/>
Early grey hair	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Urticaria	<input type="checkbox"/>	<input type="checkbox"/>
Gripping/Bowel cramps	<input type="checkbox"/>	<input type="checkbox"/>	White spots on nails	<input type="checkbox"/>	<input type="checkbox"/>

PRESENT/PREVIOUS ILLNESS OR CONDITIONS: Please tick box

	F	M		F	M
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lumbago	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mouth ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Coeliac disease	<input type="checkbox"/>	<input type="checkbox"/>	M.E.	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Multiple-Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid-arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Haemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			

ANY FURTHER INFORMATION ABOUT PRESENT/PAST ILLNESS OR CONDITIONS: *please provide details*.....

.....

.....

.....

CURRENT MEDICAL TREATMENT:

Do you regularly take? Please tick box

	F	M		F	M
Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	Painkillers	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping tablets	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	Tranquillizers	<input type="checkbox"/>	<input type="checkbox"/>

Other medication/supplements (female):

.....

Other medication/supplements (male):

.....

ARE YOU IN REGULAR CONTACT WITH?:-

	F	M		F	M
Algicides (copper containing)	<input type="checkbox"/>	<input type="checkbox"/>	Herbicides	<input type="checkbox"/>	<input type="checkbox"/>
Aluminium pans	<input type="checkbox"/>	<input type="checkbox"/>	Microwave	<input type="checkbox"/>	<input type="checkbox"/>
Aluminium kettle	<input type="checkbox"/>	<input type="checkbox"/>	Mobile phone	<input type="checkbox"/>	<input type="checkbox"/>
Ascot-type water heater	<input type="checkbox"/>	<input type="checkbox"/>	Paint stripper	<input type="checkbox"/>	<input type="checkbox"/>
Antacids	<input type="checkbox"/>	<input type="checkbox"/>	PC/VDU	<input type="checkbox"/>	<input type="checkbox"/>
Coffee-mate	<input type="checkbox"/>	<input type="checkbox"/>	Pesticides	<input type="checkbox"/>	<input type="checkbox"/>
Copper/brass jewellery	<input type="checkbox"/>	<input type="checkbox"/>	Photocopier	<input type="checkbox"/>	<input type="checkbox"/>
Electric blanket	<input type="checkbox"/>	<input type="checkbox"/>	PVC Clingfilm	<input type="checkbox"/>	<input type="checkbox"/>
Fluoridated water	<input type="checkbox"/>	<input type="checkbox"/>	Sunbed	<input type="checkbox"/>	<input type="checkbox"/>
Fly killer	<input type="checkbox"/>	<input type="checkbox"/>	Tinned foods/drinks	<input type="checkbox"/>	<input type="checkbox"/>
Foil wrap	<input type="checkbox"/>	<input type="checkbox"/>	Wallpaper remover	<input type="checkbox"/>	<input type="checkbox"/>
Food additives	<input type="checkbox"/>	<input type="checkbox"/>	(Toluene)	<input type="checkbox"/>	<input type="checkbox"/>
Gas boiler	<input type="checkbox"/>	<input type="checkbox"/>			
Gas fire/cooker	<input type="checkbox"/>	<input type="checkbox"/>			

Please tick appropriate box:

Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How many per week?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink?	<input type="checkbox"/>	<input type="checkbox"/>	How many units per week?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Details:		

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