



FORESIGHT

PRECONCEPTION QUESTIONNAIRE

Date:

Code:

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

FEMALE PARTNER

MALE PARTNER

Name

Name

Address

Address

Email

Occupation

Occupation

Tel:

Tel:

Tel (work)

Tel (work)

Age: / /

Age: / /

Ethnic origin:

Ethnic origin:

Height (m)

Height (m)

Weight (kg)

Weight (kg)

Foresight Clinician:

SPECIFIC INFORMATION FOR THIS HAIR SAMPLE Please give details:

FEMALE PRODUCT

MALE PRODUCT

Bleach/Colouring

Highlights/Tints

Perm

Shampoo

Conditioner

N.B. Please refer to Hair Test Form for details

Permanent dyes can produce a less accurate reading.

FEMALE PREVIOUS REPRODUCTIVE HISTORY

PREVIOUS CHILDREN

Sex	Birthweight	Year	Sex	Birthweight	Year
1	/	/	4	/	/
2	/	/	5	/	/
3	/	/	6	/	/

HOW MANY?

Perinatal Death(s)

Dates:

Miscariages(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) please give details

Problems during pregnancy?

Lactation e.g. how long?

Allergic illness & other health problems in children?

INFERTILITY

Years

Female

Male

Previous Fertility Treatments (success Y/N)

IVF

IUI

ICSI

Consultant

Clinic

**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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anovulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps (benign)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fallopian tubes:				
Blocked	<input type="checkbox"/>	Malformed	<input type="checkbox"/>	
Removed	<input type="checkbox"/>	Twisted	<input type="checkbox"/>	
Fibroids	<input type="checkbox"/>		<input type="checkbox"/>	
Frequency (of urine)	<input type="checkbox"/>		<input type="checkbox"/>	
Genital ulcers	<input type="checkbox"/>		<input type="checkbox"/>	

**HAVE YOU BEEN CHECKED / IF POSITIVE TREATED FOR ?**

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"/>
Candida	<input type="checkbox"/>	Klebsiella	<input type="checkbox"/>
Cervical erosion	<input type="checkbox"/>	Mycoplasma	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	Staph. Aureus	<input type="checkbox"/>
Cytomegalovirus	<input type="checkbox"/>	Strep. Millerii	<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, Aspirin

**CONTRACEPTION**

**How Long?**

**Dates**

No. of years

No. of years

Coil	<input type="checkbox"/>	Pill	<input type="checkbox"/>
Diaphragm	<input type="checkbox"/>	Sheath	<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?  Number (million) \_\_\_\_\_

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"/>	Varicocele	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	Vasectomy reversal	<input type="checkbox"/>

**HAVE YOU BEEN CHECKED / IF POSITIVE TREATED FOR ?**

Aids	<input type="checkbox"/>	Haem. Influenza	<input type="checkbox"/>
Anaerobic bacteria	<input type="checkbox"/>	Haem. Strep.	<input type="checkbox"/>
B.Strep.	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
Candida	<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"/>	Strep. Millerii	<input type="checkbox"/>
E. Coli	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
Gardnerella	<input type="checkbox"/>	Trachimonas	<input type="checkbox"/>
Genital Warts	<input type="checkbox"/>	Ureaplasma	<input type="checkbox"/>
Gonorrhoea	<input type="checkbox"/>	Toxoplasmosis	<input type="checkbox"/>

**DEFICIENCY SYMPTOMS.**

Acne	F	M	F	M
Apathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body odour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catarrh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early grey hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripping / Bowel cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PRESENT / PREVIOUS ILLNESS OR CONDITIONS Please tick box:**

	Present	Previous	Present	Previous
	F	M	F	M
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Total:	<input type="text"/>		<input type="text"/>	
	Present	Previous	Present	Previous
	F	M	F	M
Grooved tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halitosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lank hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretch marks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (heavy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urticaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White spots on nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male total:	<input type="text"/>		<input type="text"/>	

**CURRENT MEDICAL TREATMENT:**

Do you regularly take?	F	M	F	M
Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painkillers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillizers	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aluminium pans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aluminium kettle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ascot-type Water Heater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee-mate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copper/brass jewellery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electric over-blanket	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluoridated water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fly killer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foil wrap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food additives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas boiler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas fire/cooker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Avoid the above where possible)				
Greenhouse smokebombs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbicides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microwave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moth balls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paint stripper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pesticides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Photocopier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PVC Clingfilm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunbed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinned foods/drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuna fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V.D.U.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wallpaper remover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Toluene)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Female total:  Male total:

*Please tick appropriate box:*

Do you smoke?	F	M	How many a week?	F	M
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Do you drink	<input type="checkbox"/>	<input type="checkbox"/>	How many units	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	a week?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<i>-Please attach full details</i>		