Dorothy Kelly Fertility Consultation form

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| **Name:** | **DOB:** |
| **Address:** | **GP:** |
| **Tel:** | **Email:** |
| **Your weight:** | **Semen Analysis performed Yes / No**    **Result:**  **Has SA been banked? Yes / No**  **Follow up treatment? Yes / No**  **Have you had any DNA Fragmentation performed?**  **Yes / No** |
| **Do you smoke:** |
| **Occupation:** |
| **Units of alcohol taken weekly:** |
| **Any Urological problems?**  **Yes / No**  **If yes, please state:** | **Any sexually transmitted infections?**  **Yes / No** |
| **Have you conceived naturally before?**  **Yes / No** | **STIs/Mumps**  **Yes / No** |
| **Do you have children?**  **Yes / No** | **Length of time trying for a baby?** |
| **Stress levels 1 - 10,**  **10 worst, lowest 1. \_\_\_\_\_\_\_** | **How do you relax:**  **Exercise y / n Walking y /n reading y / n** |
| **Any other relevant medical history including recent surgery?** | |
| **Any ongoing Investigations?** | |
| **Any medication or supplementation:** | **Dietary habits:**  **Water intake daily:** |

I confirm to the best of my knowledge the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. The treatment

I am about to receive has been explained to me and I give my consent to reflexology. Under GDPR this information will be retained securely by me and will be held for 8 years as per recommendations of my insurance company.

**Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**