**Dorothy Kelly, Fertility Reflexology**

**Fertility Consultation Form**

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| **Name:** | **DOB:** | |
| **Address:** | **GP:** | |
| **Tel:** | **Email:** | |
| **Occupation:** | **Stress Levels (score 1 -10, 1 good,10 bad)**  **Score**: | |
| **Your weight:** | **Age of menstrual onset:**  **Regular: Not regular**  **Cycle frequency: / days**  **Aware of ovulation: Pain:** | |
| **Do you smoke:** |
| **Units of alcohol taken weekly:** |
| **Consistency of bleed:**  **Spotting: Beginning □ Mid cycle □**  **Brown stain:Beginning □Mid cycle □**    **Length of period: No: days: \_\_\_\_\_\_**  **Or several periods per month Yes/No** | **Colour of bleed: Bright red □**  **Dark red □ Clots □**  **Intermenstrual bleeding □**  **Excessive bleeding ≥ 1 pad/tampon per hour □** | |
| **Smear history: Up to date: Yes/No**  **Normal: Yes/No**  **Abnormal: Yes/No** | **Referred for Colposcopy: Yes/No**  **If Yes, result CIN 1 □ CIN 2 □ CIN 3 □**  **Any further follow-up required: Yes / No** | |
| **Painful periods? Yes / No** | **Painful Ovulation? Yes / No** | |
| **PCOS □ Endometriosis □** | **Fibroids □** | |
| **Low backache □** | **Frequent urination □** | |
| **Contraception method:**  **If Pill, have you had any problems taking Pill? Yes / No** |  | |
| **Have you managed to conceive naturally before?** | **Yes** | **No** |
| **Miscarriages? Details of weeks. 1 or more?** | **Yes** | **No** |
| **Do you have any children? Types of delivery?** |  | |
| **Any Gynaecological problems?** |  | |
| **Any sexually transmitted infections?** | **You**  **PID / Chlamydia** | **Partner**  **STIs/Mumps** |
| **How long have you been trying for a baby?** |  | |
| **Any Investigations? Tube Patency etc** | **Clear □ Blockage □** | |
| **Treatment Cycles IVF/ICSI, if yes please state how many.** |  | |
| **Has your partner had a Semen Analysis performed? Yes / No**  **Result?** | **Normal □ Low □ No sperm □**  **Comments on:**  **Morphology □ Motility □** | |
| **Any other relevant medical history including recent surgery?** |  | |
| **Details of any supplements or medication:** |  | |
| **Can you take Vitamin B Yes /No** |  | |

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. Privacy notice is available on website.

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