CONFIDENTIAL POST PARTUM CLIENT INFORMATION

TODAY'S DATE: _____

Name: _____ _____ _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h): _____ (w) _____ (cell) _____

Date of Birth: _____ Age _____

Occupation: _____ Your email _____

Referred by: _____

Age when you got your period: _____ Are your cycles regular? _____

How long is your cycle? _____

Is that the same as it has always been or has it changed? _____

If it has changed, please describe the change _____

_____

Do you know when you ovulate? _____ How do you know? _____

Have you ever been pregnant? _____ Any complications? _____

Deliveries: Vaginal _____ C-section _____ Terminations: _____ Miscarriages: _____

Are you currently under the care of another healthcare practitioners? _____

If so, why: _____

_____

Current Medications and/or supplements (list all including herbals): _____

_____

_____

Please check if you are experiencing or have experienced any of the following.

□ Painful periods

□ Painful ovulation

□ Severe cramping

□ Pain during intercourse

□ Constipation / Loose stools

□ UTI / Yeast infection

Have you ever had a sexually transmitted disease?
If so, please describe. _____

_____

Do you have a history of sexual trauma?

_____

Any other Gynecological issues I should be aware of?_____

_____

What contraceptives have you used? If the Pill, when and for how long _____

If IUD, how long and when was it removed? _____

How long have you been trying to conceive? _____

Have you been diagnosed with any known fertility challenges? _____

Please give a brief description of past and current treatments. _____

_____

_____

Have you had your uterine tubes evaluated? If so, how long ago and the results _____

_____

Has your partner had a fertility workup? If so, how long ago and the results _____

_____

Have you or your partner conceived or had children with previous partners? _____

_____

Have you ever had surgery or any procedure performed? If so, please describe._____

_____

Have any close relatives had a history of infertility or miscarriage? _____

_____

Lifestyle

Describe your exercise routine: _____

Do you use Tobacco? _____ Alcohol? Quantity (#/day)?_____

Are you following any special diet? If so, what? _____

Do you avoid any specific foods or food groups? Gluten Eggs Dairy (circle)

Other _____

How often do you eat processed foods (#/week)_____ Fast food (#/week) _____ Restaurants (#/week) _____

Any known food allergies or sensitivities _____

_____ _____

Signature Date