BENATURAL
FERTILITY WELLNESS

Couple's Fertility Awareness

Basic Information

	Wife	Husband
Name	Chong Chong	Yan Leong
Age	33	35
Address		
Mobile No.	9183 3621	9106 4993
Email		
Race / Religion	Chinese	Chinese
Nationality	Malaysia	Malaysia
Occupation	Dentist	Auditor
Number of hours worked / day	8 – 10	8
Relaxation Time hours / day	1 – 2	1
We have been married for	years 8 months	
We have been trying for	years 8 months	
How often do you have sexual intercourse per week?	1 times	

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Wife

Physical details		
Height	1.6 m	
Weight	57 kg 58.20	
BMI = (Weight) / (Height)^2	(22.4)	
Blood Pressure	114/73 mmHg	
Pulse 65	~~73~~ bpm	
Drug allergies	☑ ~~Not known~~	☐ Yes
- If yes, what type of allergy and reaction?		
Pregnancy history		
Number of previous abortions	–	
Number of previous miscarriages	–	
Number of previous full-term pregnancies	–	
Menstruation		
Age of first menstruation	12 years old	
Is your menstruation regular?	☐ No	☑ ~~Yes~~
Cycle length	Flowing for 4-5 days	
	for every 30-32 days	
Are your menstruations painful?	☐ No	☑ ~~Mild~~
	☐ Moderate	☐ Severe
Do you have heavy menstruation (soaked pad change hourly)?	☑ ~~No~~	☐ Yes
Which day of your cycle is it the heaviest?	2 day	
Do you have any bleeding between periods?	☑ ~~No~~	☐ Yes
Do you miss your period regularly?	☑ ~~No~~	☐ Yes
Sexual intercourse		
Do you experience pain during intercourse?	☑ ~~No~~	☐ Yes

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Existing medical conditions		
Do you suffer from thyroid problems?	☑ No	☐ Yes
- Are you handling it with treatment?	☑ No	☐ Yes
Do you suffer from diabetes?	☑ No	☐ Yes
- Are you handling it with treatment?	☑ No	☐ Yes
Do you suffer from high blood pressure?	☑ No	☐ Yes
- Are you handling it with treatment?	☑ No	☐ Yes
Do you suffer from high cholesterol?	☑ No	☐ Yes
- Are you handling it with treatment?	☑ No	☐ Yes
Do you suffer from anxiety?	☑ No	☐ Yes
- Are you handling it with treatment?	☑ No	☐ Yes
Do you suffer from insomnia?	☑ No	☐ Yes
- Are you handling it with treatment?	☑ No	☐ Yes
Do you have endometriosis?	☑ No	☐ Yes
Do you have polycystic ovary syndrome (PCOS)?	☑ No	☐ Yes
Do you have fibroids?	☑ No	☐ Yes
Have you had any gynaecological surgery in the past?	☑ No	☐ Yes
Have you had any abdominal surgery in the past?	☑ No	☐ Yes
- If yes, what type of surgery?	☑ No	☐ Yes
Have you had any sexually transmitted infections?	☑ No	☐ Yes
- If yes, has it been treated?	☑ No	☐ Yes
Is your last PAP smear done within a year?	☑ No	☐ Yes
Lineage		
Is there any history of autoimmune diseases in the family?	☑ No	☐ Yes
Do you have any hereditary issues that might affect fertility?	☑ No	☐ Yes