BENATURAL
FERTILITY WELLNESS

1/26/18

Saturday session ✓

Couple's Fertility Awareness

Basic Information

	Wife	Husband
Name	Jenny Cabus	John Michael Cabus
Age	31	28
Address	Blk 661 Choa Chu Kang Crescent, #02-01	Blk 661 choa chu kang Crescent ;# 02-01
Mobile No.	9451 6831	8332 1471
Email	jeni_capuno@yahoo.com	alocegnops-subac@yahoo.com.ph
Race / Religion	Filipino / catholic	Filipino / catholic
Nationality	Filipino	Filipino
Occupation	Document Controller	Telecom Engineer
Number of hours worked / day	8 hours	8 hours
Relaxation Time hours / day		8 hours
We have been married for	0 years 4 months	
We have been trying for	0 years 4 months	
How often do you have sexual intercourse per week?	2-3 times	

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Husband

Physical details		
Height	1.74 m	
Weight	75 kg	
BMI = (Weight) / (Height)^2		
Blood Pressure	mmHg	
Pulse rate	bpm	
Drug allergies	☑ Not known	☐ Yes
- If yes, what type of allergy and reaction?		
Sexual intercourse		
Do you have problems with getting or maintaining an erection?	☑ No	☐ Yes
Do you have problems with ejaculation?	☑ No	☐ Yes
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

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Have you had mumps before?	☐ No	☐ Yes
Do you have any lumps in your testicular area?	☑ No	☐ Yes
Have you had any injury to the testicles in the past?	☐ No	☐ Yes
Have you had any operation done to the testicles in the past?	☐ No	☑ Yes
Have you any semen analysis done in the past?	☐ No	☐ Yes
Have you had any urological surgery in the past?	☐ No	☑ Yes varicocele
Have you had any abdominal surgery in the past?	☑ No	☐ Yes
- If yes, what type of surgery?		
Have you had any sexually transmitted infections?	☑ No	☐ Yes
- If yes, has it been treated?	☐ 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
Lifestyle		
Do you exercise daily? 2x-3x/week	60 mins of exercise / day	
Do you consume a healthy balanced diet?	☑ No	☐ Yes
Do you smoke? before 2 years	sticks / day	
Do you consume alcohol? before 5 months	glasses of wine / day	
Do you consume caffeine?	cups / day	
Do you consume supplements?	☑ No	☐ Yes
Sudden weight change	☑ No	☐ Yes
- If yes, how much gain or loss within 1 month?	kg	
Wastes		
Do you clear your bowels regularly on a daily basis?	☐ No	☑ Yes
- If no, are you frequently constipated?	☐ No	☐ Yes
- If no, do you have diarrhoea frequently?	☐ No	☐ Yes