BENATURAL
FERTILITY WELLNESS

1/16/8

scanned

Saturdays 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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Wife

Physical details		
Height	m 5'2"	
Weight	kg 52	
BMI = (Weight) / (Height)^2		
Blood Pressure	mmHg	
Pulse	bpm	
Drug allergies	☑ Not known	☐ Yes
- If yes, what type of allergy and reaction?		
Pregnancy history		
Number of previous abortions	N/A	
Number of previous miscarriages	N/A	
Number of previous full-term pregnancies	N/A	
Menstruation		
Age of first menstruation	13 years old	
Is your menstruation regular?	☐ No	☑ Yes
Cycle length	Flowing for 7 days	
	for every 30 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? w/ blood clots	2nd 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

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Lifestyle		
Do you exercise daily?	X mins of exercise / day	
Do you consume a healthy balanced diet? X	☑ No	☐ Yes
Do you smoke?	sticks / day	
Do you consume alcohol?	glasses of wine / day	
Do you consume caffeine?	cups / day	
Do you consume supplements? USANA	☐ No	☑ Yes
Have you recently experienced 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