



BENATURAL
FERTILITY WELLNESS

✓ Saturday
pm
26/8/19
Scanned

Couple's Fertility Awareness

Basic Information

	Wife	Husband
Name	Gonzalza Hernandez	Gayle Hernandez
Age	39	39
Address	Blk 508 Woodlands Dr. 14, 08-102 (S) 730508	Blk 508 Woodlands Dr. 14, 08-102 (S) 730508
Mobile No.	9782 0650	9643 2500
Email	gonzalza_kine@yahoo.com	imgayla19@gmail.com
Race / Religion	Catholic	Catholic
Nationality	Filipino	Filipino
Occupation	Medical Technologist	Civil Engineer
Number of hours worked / day	7.5 hrs	9.5
Relaxation Time hours / day	5	4
We have been married for	7 years 2 months	
We have been trying for	5 years months	
How often do you have sexual intercourse per week?	1~2 times	



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Wife

Physical details		
Height	1.23 m	
Weight	63 kg	
BMI = (Weight) / (Height) ²		
Blood Pressure	136/91 mmHg	
Pulse	80 bpm	
Drug allergies	<input checked="" type="checkbox"/> Not known	<input type="checkbox"/> Yes
- If yes, what type of allergy and reaction?		
Pregnancy history		
Number of previous abortions	0	
Number of previous miscarriages	0	
Number of previous full-term pregnancies	0	
Menstruation		
Age of first menstruation	11 years old	
Is your menstruation regular?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Cycle length	Flowing for 3 days	
	for every +30 days	
Are your menstruations painful? P ₂	<input type="checkbox"/> No	<input type="checkbox"/> Mild
	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Do you have heavy menstruation (soaked pad change hourly)?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Which day of your cycle is it the heaviest?	2ND day w/ blood clots	
Do you have any bleeding between periods?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you miss your period regularly?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Sexual intercourse		
Do you experience pain during intercourse?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes



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Lifestyle		
Do you exercise daily?	mins of exercise / day	
Do you consume a healthy balanced diet?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you smoke?	sticks / day	
Do you consume alcohol?	glasses of wine / day	
Do you consume caffeine?	1 cups / day	
Do you consume supplements?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Have you recently experienced sudden weight change?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
- If yes, how much <u>gain</u> or loss within 1 month?	10 kg	
Wastes		
Do you clear your bowels regularly on a daily basis?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
- If no, are you frequently constipated?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- If no, do you have diarrhoea frequently?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes