



BENATURAL
FERTILITY WELLNESS

Couple's Fertility Awareness ✓

Basic Information

	Wife	Husband
Name	Helen Miao	Ray Phay
Age	45	34
Address	BK 22 St. George's Rd. #12-184 SC 321022	Same as left
Mobile No.	9736 7287	9129 2435
Email	helenmyf@gmail.com	gen2live@hotmail.com
Race / Religion	Chinese / Christian	Chinese / Christian
Nationality	Mal'ian / SPR	Singaporean
Occupation	HR Director	Recruiter
Number of hours worked / day	9-10 hours	8 hours
Relaxation Time hours / day	4 hours	6 hours
We have been married for	5 years 4 months	
We have been trying for	5 years months	
How often do you have sexual intercourse per week?	2-3 times	

gynae check-up > 2 years ago
> (N)

> No Female Hormone blood test

helenmyf@gmail.com



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Wife

Physical details		
Height	1.65 m	164
Weight	50 kg	48.95
BMI = (Weight) / (Height) ²	18	
Blood Pressure	106/74	mmHg
Pulse	72	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	-	
Number of previous miscarriages	-	
Number of previous full-term pregnancies	-	
Menstruation		
Age of first menstruation	12 years old	
Is your menstruation regular?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Cycle length	Flowing for 6-7 days	
	for every 23-25 days <i>regular</i>	
Are your menstruations painful?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Mild
	<input 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?	day 2 day 1-02 <i>no blood clots</i>	
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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Existing medical conditions		
Do you suffer from thyroid problems?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you handling it with treatment?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you suffer from diabetes?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you handling it with treatment?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you suffer from high blood pressure?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you handling it with treatment?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you suffer from high cholesterol?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you handling it with treatment?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you suffer from anxiety?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you handling it with treatment?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you suffer from insomnia?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- Are you handling it with treatment?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have endometriosis?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have polycystic ovary syndrome (PCOS)?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have fibroids?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had any gynaecological surgery in the past?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Have you had any abdominal surgery in the past?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- If yes, what type of surgery?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Have you had any sexually transmitted infections?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- If yes, has it been treated?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Is your last PAP smear done within a year?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Lineage		
Is there any history of autoimmune diseases in the family?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any hereditary issues that might affect fertility?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes



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Lifestyle		
Do you exercise daily? <i>NO</i>	mins of exercise / day	
Do you consume a healthy balanced diet?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Do you smoke? <i>No</i>	sticks / day	
Do you consume alcohol? <i>No</i>	glasses of wine / day	
Do you consume caffeine?	< 1 cups / day	
Do you consume supplements? <i>Vit-C } not Vit-B } multivitamin</i>	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Have you recently experienced sudden weight change?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
- If yes, how much gain or loss within 1 month?	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