



BENATURAL
FERTILITY WELLNESS

Couple's Fertility Awareness

double entry

Basic Information

OLYN

	Wife	Husband
Name	MENDOZA JOCELYN JIMENO	
Age	43	
Address	9 SIMET ST. 4, H02-05 SIMET GREEN, (S) 529865	
Mobile No.	9627 5499	
Email	jocelynjimendoza@gmail.com	
Race / Religion	FILIPINO / CATHOLIC	
Nationality	SINGAPOREAN	
Occupation	QA ANALYST	IT
Number of hours worked / day	8 HRS / DAY (SOMETIMES > 10 HRS)	
Relaxation Time hours / day	~ 4 HRS	
We have been married for	15 years 2 months	
We have been trying for	years 5 months	
How often do you have sexual intercourse per week?	times OCCASIONAL	

1 child - Boy 7 years

2014 - 17 wks - FH not seen

Feb 2017 - 6 wks - FH is weak (1 week later No FH seen)





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Wife

Physical details		
Height	m	
Weight	54 kg 54.7	
BMI = (Weight) / (Height) ²	24	
Blood Pressure	104/69 mmHg	
Pulse	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	2	
Number of previous full-term pregnancies		
Menstruation		
Age of first menstruation	18 years old <i>at hormonal medication to induce menses</i>	
Is your menstruation regular?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Cycle length	D2 - <i>delayed menses</i>	
	Flowing for 4 days	
	for every > 30 days	
Are your menstruations painful?	<input type="checkbox"/> No	<input type="checkbox"/> Mild
	<input checked="" type="checkbox"/> Moderate <i>bearable in pain</i>	<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?	2 day	
Do you have any bleeding between periods?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Do you miss your period regularly?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Sexual intercourse		
Do you experience pain during intercourse?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes



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Wife

X box

Lifestyle		
Do you exercise daily?	<i>zero</i>	mins of exercise / day
Do you consume a healthy balanced diet?	<input type="checkbox"/> No	<input 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?	<i>Ten occasionally</i>	cups / day
Do you consume supplements?	<i>Folic</i>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Have you recently experienced sudden weight change?	<input 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 <i>constipated</i>
- If no, are you frequently constipated?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
- If no, do you have diarrhoea frequently?	<input type="checkbox"/> No	<input type="checkbox"/> Yes