



Female Pre-Conception Health Questionnaire

These questions have been designed to give a clear picture of your present health status and to identify any potential health problems that may affect a future pregnancy. All your answers are confidential and will only be seen by the health assessor. However, should a significant health problem be detected requiring medical investigation, you will be given a letter to take to your GP.

You should receive a summary within seven to ten days of your assessment. If you give your e-mail address, your summary will be sent electronically.

Name:

Date of Birth:

Address:

Tel No:

E-mail:

GP Name & Address:

Occupation:

Hours of work per week:

Personal Medical History

Please put for YES and for NO. Leave blank if unsure.

If you answer YES, please give brief details in Supplementary Information section.

1) Do you or have you ever suffered from any of the following cardiovascular diseases or disorders?

Heart Attack	Angina	Recurrent Chest Pain	Palpitations	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	Rheumatic	Irregular Pulse	Valve Disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

2) Do you or have you ever suffered from any of the following diseases or disorders of the brain?

Stroke	Dizziness	Epilepsy	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3) Do you or have you ever suffered from any of the following nervous disorders?

Anxiety	Depression	Stress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4) Do you or have you ever suffered from any of the following respiratory diseases or disorders?

Asthma Chronic Bronchitis Tuberculosis Coughing Up Blood

5) Do you or have you ever suffered from any disease or disorder of the following genito-urinary organs?

Kidneys Bladder (eg cystitis)

6) Do you or have you ever suffered from any of the following diseases or disorders of the digestive system?

Peptic Ulcer Recurrent Diarrhoea Recurrent Constipation Rectal Bleeding

Ulcerative Colitis Crohn's Disease Irritable Bowel Syndrome

7) Do you or have you ever suffered from any of the following liver disorders?

Jaundice Hepatitis Cirrhosis

8) Do you or have you ever suffered from any of the following diseases or disorders of the muscles or joints?

Slipped Disc Osteoarthritis Rheumatoid Arthritis Gout

9) Do you or have you ever suffered from any of the following endocrine conditions?

Diabetes Type 1 Diabetes Type 2 Glandular Disease Thyroid Disorder

10) Do you or have you ever suffered from any disease or disorder of the following?

Skin Eyes Ears Nose Throat Mouth

11) Have you ever been diagnosed as having any form of the following?

Cancer Tumour Cyst Lump

If yes, where in the body?

12) Have you ever suffered from any of the following blood disorders?

Anaemia

Leukaemia

13) Do you suffer from any of the following progressive debilitating diseases?

Multiple Sclerosis

Parkinson's Disease

Muscular Dystrophy

14) Have you ever undergone any of the following investigations (excluding pregnancy)?

Xray

ECG

CT Scan

MRI Scan

Ultrasound

Blood Test

15) Have you ever undergone a surgical operation? If yes, give details below

16) Have you ever suffered from any serious injury requiring hospital treatment?

17) Have you ever received treatment from a Complementary Health Practitioner?

Supplementary Information	
<i>Please insert question number and relevant details in the space provided</i>	
Question Number	Brief Details ie. condition, dates, investigations, duration of treatment etc

Gynaecological HistoryWhat age were you when your periods began? Are your periods regular? Approx. no. of days of cycle? Do you suffer from Pre-Menstrual Tension? Have you used a medicated form of contraception? (eg pill, injection, coil)

If yes, which type(s)?

If you are still using a medicated form of contraception, state which one

Pregnancy History - please fill in this section if you have been pregnant in the pastHow many live births have you had? Have you had any miscarriages? If yes, how many? How many weeks pregnant were you?Have you ever had a Caesarian Section? Did you breast feed ? If yes, what was the longest time in months/weeks that you breast fed? Do you routinely examine your breasts for lumps? Have you ever noticed a breast lump? If yes, did you seek medical advice?

What was the outcome?

When did you have your last cervical smear test? Have you ever had an abnormal cervical smear? If so, when? Have you ever been diagnosed with a sexually transmitted disease?

If yes, please state the name of the disease(s)

If yes, how long ago did you have the disease?

What treatment were you given?

Have you been diagnosed with Endometriosis? Have you been diagnosed with Polycystic Ovaries? Have you ever been treated for Infertility? Have you had a blood test for Hughes Syndrome (sticky blood syndrome)? Have you had a blood test for toxic heavy metals? Have you ever had a Hair Mineral Analysis for toxic metals and mineral ratios? Have you had a hormone profile test? Blood Test Saliva Test

Medication: Please state the medicines you are currently taking

Name of Medicine	Dosage	Times taken per day
.....
.....
.....

Nutritional or Herbal Supplements: Please state any you are currently taking

Name of Supplement	Dosage	Times taken per day
.....
.....
.....

Allergies or Intolerances:

Do you suffer from any allergies?
 If yes, what are you allergic to?

Has your allergy been confirmed by a specialist or test?

Do you suffer from any food intolerances?
 If yes, what are you intolerant to?

Has your intolerance been confirmed by a specialist or test?

Smoking Status:

Do you smoke? If yes, please state Cigarettes Cigars Pipe Other

How many a day? Do you intend to give up smoking soon?

If you do not smoke now, have you ever smoked?

If yes, please state Cigarettes Cigars Pipe Other

When did you stop smoking?

Alcohol Status:

One unit = ½ pint of Beer/Cider, a small glass of wine, or a pub measure of spirits

What is your average weekly consumption of alcohol in units?

If <1, how many units a month? Did you regularly drink more in the past?

Do you drink more than 2 units a day? Never Occasionally x1/week or more Every Day

Dietary History:Do you eat at least 3 meals a day?

If not, which meal(s) do you miss?

Do you eat at least 5 portions of fruit and vegetables a day? Do you eat meat? Do you eat fish? Are you a Vegetarian/Vegan? Do you include roughage (high fibre foods) in your diet? Do you eat convenience/processed food and takeaways? If yes, how often? <1 a week 1-2 x a week 3-6 x a week Every day Do you eat organic produce? Regularly Occasionally Never Do you usually add sugar to beverages or breakfast cereals? Do you use artificial sweeteners? If so, which brand?How many glasses of water do you drink a day? Do you drink tap water? Is your water fluoridated? Do you use a water filter? How many glasses of fruit juice do you drink a day? Do you drink caffeinated tea or coffee? No. of cups of tea Cups of coffee Do you drink fizzy drinks? How many a week? Do you drink diet versions? **Exercise:**Do you have a regular exercise routine? Do you do at least ½ hour of brisk exercise five times a week?

If not, how much exercise do you do in a week?

What type(s) of exercise/activity do you do?

Do you have a sedentary job? Do you often drive short distances rather than walk? Do you normally take the lift or escalator rather than the stairs? Do you have a disability that prevents you from exercising? Do you find time to relax each day?

Dental History:

When did you last visit a dentist?

Do you have mercury fillings?

Do you suffer from mouth ulcers? If yes, how often? Occasionally Regularly

Do you use a toothpaste containing fluoride?

Do you use a mouthwash containing alcohol?

Chemical Exposure:

Do your toiletries contain any of the following ingredients?

Sodium Lauryl Sulphate	Sodium Laureth Sulphate	Propylene Glycol	DEA / TEA / MEA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talc	Isopropyl	DMDM hydantoin	Imidazolidinyl urea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Aluminium	Butylated hydroxytoluene
		<input type="checkbox"/>	<input type="checkbox"/>

Do you use air fresheners (any type)?

Do you use supermarket or main brands of household cleaning products?

Family History:

Have close members of your family suffered from any of the following diseases or disorders?
Please put **M** for mother, **F** for father, **S** for sister or **B** for brother.

Diabetes Type 1 (Insulin dependent) Diabetes Type 2 (Non-Insulin dependent)

Stroke Heart Attack High Blood Pressure High Cholesterol

Osteo-arthritis Rheumatoid Arthritis Osteoporosis

Alzheimer's Disease Kidney Disease Respiratory Disease

Glaucoma Cancer If yes, where is/was the cancer?

Are both your parents still alive? If no, what age did they die? **M** **F**

What caused their death?

M

F

