Nutritional Therapist: **LYNN ALFORD-BUROW** Dip ION, MBANT

Please fill in this form as fully as possible and post back to
Lynn Alford-Burow, CINNAMON HEALTH, Cinnamon House, 21 Winner Hill Road, PAIGNTON, Devon, TQ3 3BT
to arrive in good time before your appointment. Or alternatively, please briing it along with you for your appointment.

cinnamonhealth
Nutritional Therapy

PRECONCEPTION QUESTIONNAIRE

ALL INFORMATION IN THIS DOCUMENT WILL BE TREATED IN STRICTEST CONFIDENCE.

Date:

FEMALE PARTNER

First Name:

Surname:

Address:

Email:

Day Tel:

Eve Tel:

Mobile:

Age: DOB / /

Ethnic Origin:

Height (m):

Weight (kg):

Occupation:

MALE PARTNER

First Name:

Surname:

Address:

Email:

Day Tel:

Eve Tel:

Mobile:

Age: DOB / /

Ethnic Origin:

Height (m):

Weight (kg):

Occupation:

FEMALE PREVIOUS REPRODUCTIVE HISTORY

PREVIOUS CHILDREN

	Sex	Birthweight	Year
1			
2			
3			
4			
5			
6			

HOW MANY?

Perinatal Death(s)	Dates:
Miscarriage(s)	Dates:
Premature Birth(s)	Dates:
Therapeutic Termination(s)	Dates:
Stillbirth(s)	Dates:
SIDS (Sudden Infant Death)	Dates:
Small Baby(s) at term	Dates:

Malformation(s) please give details

Problems during pregnancy?

Lactation e.g. how long?...

....

....

Allergic illness and other health problems in children?...

....

....

....

....

....

INFERTILITY

Female...(Years) Male ....(Years)

Previous Fertility Treatments (success Y/N)

IVF ☐ ☐ ☐ ☐ ☐ IUI ☐ ☐ ☐ ☐ ☐ ICSI ☐ ☐ ☐ ☐ ☐

Consultant... Clinic ....

FEMALE GYNAECOLOGICAL HISTORY

Do you/ or Did you ever suffer from any of the following? (Please tick appropriate box if yes)

	Do	Did		Do	Did
Amenorrhea (no periods)	☐	☐	Low back pain	☐	☐
Anovulation	☐	☐	Malformed womb	☐	☐
Breast lumps (benign)	☐	☐	Ovulation pain	☐	☐
Breast cancer	☐	☐	Ovarian cysts	☐	☐
Cystitis	☐	☐	Pain on intercourse	☐	☐
Endometriosis	☐	☐	Painful periods	☐	☐
Fallopian tubes:			Premenstrual tension	☐	☐
Blocked ☐ Malformed ☐ Removed ☐ Twisted ☐			Thrush	☐	☐
Fibroids	☐	☐	Vaginal discharge	☐	☐
Frequency of urination	☐	☐	Vaginal burning	☐	☐
Genital ulcers	☐	☐	Vaginal irritation or itchyness	☐	☐
Irregular periods	☐	☐	Water retention	☐	☐

Have you been checked for/ or if positive – treated for any of these conditions?

	Checked	Treated		Checked	Treated
Aids	☐	☐	Gonorrhea	☐	☐
Anaerobic bacteria	☐	☐	Haem. Influenza	☐	☐
B.Strep.	☐	☐	Haem. Strep.	☐	☐
Blocked tubes	☐	☐	Herpes	☐	☐
Candida	☐	☐	Klebsiella	☐	☐
Cervical erosion	☐	☐	Mycoplasma	☐	☐
Chlamydia	☐	☐	Staph. Aureus	☐	☐
Cytomegalovirus	☐	☐	Strep. Millerii	☐	☐
Enterococcus	☐	☐	Syphilis	☐	☐
E.Coli	☐	☐	Toxoplasmosis	☐	☐
Gardnerella	☐	☐	Trachimonas	☐	☐
Genital warts	☐	☐	Ureaplasma	☐	☐

Any further information about present/past infertility treatment: ....

....

....

....

....

....

Fertility Drugs taken currently e.g. Clomid, Danazol, Heparin, Aspirin ....

....

Fertility Drugs taken in the past ....

....

....

CONTRACEPTION How long used? .... Dates ....

	No of Years		No of Years
Coil (Which)	☐	Pill (Which)	☐
Diaphragm	☐	Sheath	☐
Female condom	☐	Sponge	☐
Natural family planning	☐	None	☐
Persona	☐		

Have you been immunised for Rubella? Yes ☐ No ☐ When? .... When checked? ....

MALE FERTILITY STATUS (Please tick appropriate box if yes)

Have you had a sperm count? ☐ Number (million) ....

Percentage malformed sperm ....

Percentage of immotile sperm ....

Clumping? ....

In the past have you had any of the following:

Mumps	☐	Testicular cancer	☐
Non-specific urethritis	☐	Varicoceal	☐
Rubella	☐	Vasectomy reversal	☐

Have you been checked for/ or if positive – treated for any of these conditions?

	Checked	Treated		Checked	Treated
Aids	☐	☐	Haem. Influenza	☐	☐
Anaerobic bacteria	☐	☐	Haem. Strep.	☐	☐
B.Strep.	☐	☐	Herpes	☐	☐
Candida	☐	☐	Klebsiella	☐	☐
Chlamydia	☐	☐	Mycoplasma	☐	☐
Cytomegalovirus	☐	☐	Staph. Aureus	☐	☐
Enterococcus	☐	☐	Strep. Millerii	☐	☐
E.Coli	☐	☐	Syphilis	☐	☐
Gardnerella	☐	☐	Toxoplasmosis	☐	☐
Genital warts	☐	☐	Trachimonas	☐	☐
Gonorrhea	☐	☐	Ureaplasma	☐	☐

DEFICIENCY SYMPTOMS - Do you have now, or have you suffered frequently from any of these?

	F	M		F	M
Acne			Grooved tongue		
Apathy			Hair loss		
Back pain			Halitosis (bad breath)		
Bleeding gums			Headaches		
Bloating			Insomnia		
Body odour			Irritability		
Brittle nails			Lank hair		
Bruising			Memory loss		
Catarrh			Nervousness		
Cold hands/feet			Palpitations		
Constipation			Panic attacks		
Cramps			Sensitivity to light		
Dandruff			Sensitivity to noise		
Dental decay			Short sight		
Diarrhoea			Stretch marks		
Dizziness/Vertigo			Sweating (heavy)		
Early grey hair			Tinnitus		
Fatigue			Urticaria		
Griping/bowel cramps			White spots on nails		

PRESENT/PREVIOUS ILLNESS OR CONDITIONS (Please tick appropriate box)

	Present		Previous			Present		Previous	
	F	M	F	M		F	M	F	M
Anorexia					High blood pressure				
Arthritis					Irritable bowel				
Astma					Lumbago				
Cancer					Migraine				
Coeliac disease					Mouth ulcers				
Depression					Myalgic Encephaloopathy (M.E,)				
Diabetes					Multiple Sclerosis (M.S.)				
Dyslexia					Obesity				
Ear infections					Psoriasis				
Eczema					Rheumatism				
Epilepsy					Rheumatoid-Arthritis				
Haemorrhoids					Sciatica				
Heart disease					Varicose veins				
FEMALE TOTAL:	___		___			___		___	
MALE TOTAL:		___		___			___		___

FEMALE GRAND TOTAL:

MALE GRAND TOTAL:

CURRENT MEDICAL TREATMENT - Do you regularly take?

	F	M		F	M
Antidepressants	☐	☐	Painkillers	☐	☐
Diuretics	☐	☐	Sleeping tablets	☐	☐
Insulin	☐	☐	Steroids	☐	☐
Laxatives	☐	☐	Tranquillisers	☐	☐

Other medication/supplements (female):...

....

....

Other medication/supplements (male): ....

....

....

ARE YOU IN REGULAR CONTACT WITH OR DO YOU USE FREQUENTLY?:

	F	M		F	M
Algicides (copper containing)	☐	☐	Herbicides	☐	☐
Aluminium pans and/or kettle	☐	☐	Microwaved food or from canteen/restaurant	☐	☐
Antacids	☐	☐	Moth balls	☐	☐
Artificial sweeteners/Aspartame/Splenda/Nutrasweet etc	☐	☐	Paint stripper	☐	☐
Ascot-type water heater	☐	☐	Pesticides	☐	☐
Coffee-mate or creamers	☐	☐	Photocopier	☐	☐
Copper/brass/lead jewellery	☐	☐	Power shower	☐	☐
Electric over-blanket	☐	☐	PVC clingfilm for food wrapping/storage	☐	☐
Fluoridated water	☐	☐	Sunbed and/or Fake tan lotions/sprays	☐	☐
Fly killer/insecticides	☐	☐	Tefal/Teflonlined cooking pans	☐	☐
Foil wrap for storage or cooking	☐	☐	Tinned foods/drinks	☐	☐
Food additives	☐	☐	Tuna fish and/or Farmed fish such as salmon	☐	☐
Gas boiler	☐	☐	V.D.U.	☐	☐
Gas fire/cooker	☐	☐	Wallpaper remover (toluene)	☐	☐
Greenhouse smokebombs	☐	☐			
FEMALE TOTAL:	___			___	
MALE TOTAL:		___			___

FEMALE GRAND TOTAL: ☐

MALE GRAND TOTAL: ☐

	F	M		F	M
Do you smoke?	☐	☐	How many a week?	☐	☐
Do you drink alcohol?	☐	☐	How many units a week?	☐	☐
Do you use drugs:	☐	☐	*Please attach full details in strictest confidence*		

Which brand of shampoo do you use?:...

Which brand of conditioner do you use?: ....

Which brand of deodorant/anti-perspirant do you use?: ....

Which brand of soap do you use?: ....

Which brand of hand cream and/or body lotion do you use?:...

Which brand of hair dye do you use if used?: ....