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| **Client’s File** |

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| **Personal information** |

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| **Full name:****Date of birth:****Phone number:****E-mail:****Marital status:****Height:****Weight:** |

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| **Answer the below questions:** |

1. **How is your menstrual period cycle?**
* Regular
* Irregular
* Absent
1. **How is your blood flow during your period?**
* Normal
* Low
* Very low
* Heavy
* Heavy flow and long period (*beyond days*)

*Additional comments about your flow* ……………………………………………………………………………………………………………………………………………..

1. **Have you been medically diagnosed with:**
* Endometriosis
* Adenomyosis
* Low ovarian reserve
* Tight cervix
* Tilted cervix
* Premature menopause
* PCOS *(Polycystic Ovary Syndrome)*
* Hashimoto
* Thyroid
* Diabetes
* High blood pressure
* None

***Other(s)*** ……………………………………………………………………………………………………………………………

1. **Are you currently under any medication?**
* Yes
* No

**If yes, which one(s)** …………………………………………………………………………………………………………….………………...

1. **Do you take any vitamin(s)/supplement(s)?**
* Yes
* No

**If yes, which one(s)** ……………………………………………………………………………………………………………..

1. **Have you ever been pregnant?**
* Yes
* No

If yes, was it:

* Natural pregnancy
* IVF (*please specify the number of IVF trials*) ..............................................................................
1. **Have you ever experienced miscarriage(s)?**
* Yes
* No

If yes, do you know on which day of your pregnancy the miscarriage happened?

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1. **Have you ever experienced abortion?**
* Yes
* No
1. **Do you use any lubricant(s) during your personal intercourse?**
* None
* Commercial water-based lubricants
* Natural oils (*coconut oil/olive oil*)
* Saliva
* Vaseline
1. **Do you smoke?**
* Yes
* No
1. **Do you drink alcohol?**
* Yes
* No