# Fertility Circle Plus Members

**Return this form and your blood work to** [**admin@carmenmair.com**](mailto:admin@carmenmair.com)

* **Subject line:  First & Last Name> – Cycle Day Labs**
* **Body of email: Add any extra information you feel is relevant (symptoms, recent changes, questions, etc.).**

**I will review your results and reply within 5 business days with tailored guidance and - if required - updates to your 12‑Week Fertility Program.**

**Love, Carmen**

|  |  |
| --- | --- |
| Full Name |  |
| Date of birth |  |
| Email address |  |
| Mobile phone |  |
| City and country of residence |  |
| Height |  |
| Weight |  |
| Waist circumference in centimetres (measured at the narrowest point after exhale) |  |
| Hip circumference in centimetres (measured at the widest part of hips) |  |
| Usual daily activity level  • Sedentary  • Lightly active  • Moderately active  • Very active |  |
| Occupation |  |
| Number of children (living) |  |
| Primary method of contraception used in the past twelve months, if any |  |
| Date last menstrual period began (Day 1) |  |

|  |  |
| --- | --- |
| Average cycle length in days (first day of bleeding to next first day) [Numeric] |  |
| Is your cycle length consistent month to month [Single choice: always | often | sometimes | never] |  |
| Longest cycle in days in the last twelve months |  |
| Shortest cycle in days in the last twelve months |  |
| Days of active bleeding per period |  |
| Flow intensity on heaviest day [light | moderate | heavy | flooding with clots] |  |
| Presence of clots larger than a five-cent coin [Yes | No] |  |
| Colour of menstrual blood on day one [bright red | dark red | brown | mixed] |  |
| Premenstrual spotting number of days before flow begins |  |
| Severity of menstrual cramps on a 0-10 scale |  |
| Physical premenstrual symptoms [breast tenderness | bloating | headaches | insomnia | cravings | none] |  |
| Do you track basal body temperature [Yes | No] |  |
| If yes, for how many consecutive cycles have you recorded BBT? |  |
| What method or device are you using? (example: oral thermometer, Tempdrop, Oura Ring) |  |
| Do your charts show a clear mid-cycle temperature rise of at least 0.3 °C sustained for 10 days or more? |  |
| Do temperatures drop more than 0.2 °C / 0.36 °F two or more days before bleeding starts? |  |
| Typical luteal phase length in days if known (ovulation to next bleed) |  |
| Have luteal temperatures ever failed to stay above 36.5 °C (<97.7°F ) [Yes | No | Not tracked] |  |
| Cervical mucus observation mid cycle [egg-white stretchy | creamy only | none noticed | not sure] |  |
| Positive urine ovulation predictor kits per cycle [Yes | No | Not used] |  |
| Diagnosed hormonal conditions [Multiple choice: PCOS | endometriosis | fibroids | adenomyosis | premature ovarian insufficiency | none diagnosed] |  |
| Thyroid condition diagnosed [Yes | No] |  |
| If yes, specify and provide most recent TSH, free T4, free T3 [Short text] |  |
| Pelvic inflammatory disease ever diagnosed [Yes | No] |  |
| Past pelvic surgeries (laparoscopy, cyst removal, fibroid removal) [Short text] |  |
| Previous pregnancies |  |
| Live births |  |
| Miscarriages (under 12 weeks) |  |
| Losses after 12 weeks |  |
| Ectopic pregnancies |  |
| Terminations |  |
| Year of most recent pregnancy outcome [Date] |  |
| How long have you been actively trying to conceive this time [Numeric months] |  |
| Contraception methods used previously and total duration [Short text] |  |
| Any copper or hormonal IUD ever inserted [Yes | No] |  |
| Date removed (if applicable) [Date] |  |
| Smoking history in years |  |
| Alcohol units per week |  |
| Soft Drink units per week |  |
| Caffeine servings per day |  |
| List all current prenatal brand, multivitamin, or targeted fertility supplements |  |
| Have you implemented dietary changes for fertility (e.g. Mediterranean, low carb, dairy elimination) [Short text] |  |
| Main sources of dietary protein in a typical week [Multiple choice: red meat | poultry | fish | eggs | legumes | protein powder] |  |
| Do you consume gluten daily [Yes | No | Occasionally] |  |
| Do you consume dairy daily [Yes | No | Occasionally] |  |
| Average hours of sleep per night |  |
| Quality of sleep on a 0-10 scale |  |
| Perceived stress level [low | moderate | high | overwhelming] |  |
| Regular stress-management practices in place [meditation | breathwork | prayer | exercise | journaling | therapy | none] |  |
| How many days per week do you engage in physical activity for 30 minutes or more? |  |
| What type of activity do you do most often?[walking, strength training, HIIT, yoga, stretching, none] |  |
| Do you sweat easily when moving or exercising? [Yes | No] |  |
| How many hours per day do you sit without significant movement? |  |
| List any prescription medications you take daily. |  |

**IMMPORTANT: When you send me any additional blood test results, please specify the menstrual cycle day on which the sample was taken.**

**Medical Disclaimer**

The information and guidance provided by Carmen Mair, Nutrition and Health Coach, are intended for educational and informational purposes only and are not a substitute for medical advice, diagnosis, or treatment from a licensed healthcare provider. Carmen Mair does not diagnose, treat, or cure medical conditions. Always consult your doctor, specialist, or other qualified health professional before making changes to your diet, supplements, medications, or lifestyle—especially if you are managing a health condition, are pregnant, breastfeeding, or taking prescription drugs. Participation in any assessment or program is voluntary, and you remain fully responsible for your health decisions. Discontinue any recommended changes and seek immediate medical attention if you experience adverse symptoms. Results may vary based on individual circumstances.