# Fertility Circle Premium Member

#  Fertility Assessment

This form is designed to explore your health at a **deep, holistic level**, spanning physical, emotional, nutritional, and spiritual dimensions. It helps us uncover root causes behind fertility challenges far beyond surface symptoms.

**Instructions:**

* **Take your time.** You don’t need to complete it in one sitting.
* Answer **honestly and intuitively**, even if unsure. If a question feels irrelevant or unclear, leave it blank.
* Many sections are **symptom-based**; mark what applies to you, even if not formally diagnosed.
* If you’ve tracked your cycle, symptoms, or lab results, **include specific dates or values** where possible.
* Your responses are fully confidential and treated with respect and compassion.

This form is a **sacred space** for self-reflection and insight. The more you share, the deeper we can go.

**Return this form, food & drink journal, and your blood work to 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 |  |
| Primary method of contraception used in the past twelve months, if any |  |
| Current pregnancy status • Trying to conceive • Pregnant • Postpartum (<12 months) • Not trying / preventing |  |
| Date last menstrual period began (Day 1) |  |

|  |  |
| --- | --- |
| Age at first menstrual period  |  |
| 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  |  |
| Do cramps improve with magnesium, heat, or anti-inflammatories [Yes | No | Not sure] |  |
| Premenstrual emotional symptoms you experience [anxiety | irritability | low mood | tearfulness | rage | none] |  |
| Physical premenstrual symptoms [breast tenderness | bloating | headaches | insomnia | cravings | none] |  |
| Mid-cycle pain or twinge suggesting ovulation [Yes | No | Sometimes] |  |
| 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] |  |
| History of sexually transmitted infections [Multiple choice: chlamydia | gonorrhoea | herpes | HPV | none] |  |
| Pelvic inflammatory disease ever diagnosed [Yes | No] |  |
| Past pelvic surgeries (laparoscopy, cyst removal, fibroid removal) [Short text] |  |
| Live births  |  |
| If applicable: Age of children |  |
| Miscarriages (under 12 weeks) |  |
| Losses after 12 weeks  |  |
| Ectopic pregnancies  |  |
| Terminations  |  |
| How long have you been actively trying to conceive this time [Numeric months] |  |
| Have you ever achieved pregnancy with fertility medication or IVF [Yes | No] |  |
| Fertility treatments tried to date [Multiple choice: clomiphene | letrozole | gonadotropin injections | IUI | IVF | none] |  |
| Have you confirmed ovulation with blood progesterone (Day 21) or scan? |  |
| Most recent AMH result and date [Short text] |  |
| Most recent antral follicle count and date [Short text] |  |
| Have you had a hysterosalpingogram or HyCoSy to assess tubal patency [Yes | No | Scheduled] |  |
| Any uterine or fundal polyps, septum, or adhesions found on imaging [Yes | No | Unsure] |  |
| Current partner semen analysis within last twelve months [normal | mild factor | moderate factor | severe factor | not tested] |  |
| Frequency of intercourse timed around ovulation [daily | every second day | twice per week | less] |  |
| Typical level of vaginal lubrication during intercourse when aroused [adequate | sometimes dry | always need lubricant] |  |
| Pain with intercourse (dyspareunia) [Yes | No | Sometimes] |  |
| History of vaginal infections in the past year [bacterial vaginosis | yeast | trichomonas | none] |  |
| 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. |  |
| Has your partner completed a laboratory semen analysis within the past 12 months? [Yes | No] |  |
| If yes, please provide test date and the following reported values: volume, concentration (million ml), total motility %, progressive motility %, morphology %, DNA fragmentation index %. |  |
| Were any parameters flagged as below reference range? If so, which ones and what advice was given? |  |
| If no analysis has been done, is your partner willing to arrange one? [Yes | No] |  |
| If applicable, date and value of your latest ferritin test. |  |
| If applicable, date and values of most recent fasting glucose, fasting insulin, HbA1c.  |  |
| If applicable, date of most recent cycle day-3 reproductive hormones. List FSH, LH, estradiol (E2). |  |
| If applicable, date of most recent mid-luteal progesterone test and the cycle day it was drawn. Provide the value. |  |

**Rate each question is on a 1–5 Likert scale (1 = Never, 5 = Always). Mark with x**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | 1 | 2 | 3 | 4 | 5 |
| I smoke cigarettes or vape daily |   |   |   |   |   |
| I use recreational drugs regularly |  |  |  |  |  |
| I eat take out weekly |  |  |  |  |  |
| Have you been diagnosed with high blood pressure? |   |   |   |   |   |
| I heal quickly |   |   |   |   |   |
| Do you consume alcohol daily? |   |   |   |   |   |
| Do you wake feeling rested most mornings? |   |   |   |   |   |
| I generally have ample energy throughout the day |   |   |   |   |   |
| I exercise more than 3 times a week for more than 30 min |   |   |   |   |   |
| I can cope well with most things that life throws at me |   |   |   |   |   |
| I have a close group of people I can confide in |   |   |   |   |   |
| I get colds, sinus infections, or other illnesses more than 3 times per year. |  |  |  |  |  |
| I experience joint or muscle pain more than once a week. |  |  |  |  |  |
| I have a bowel movement at least once daily. |  |  |  |  |  |
| I eat a good breakfast every day |   |   |   |   |   |
| I drink more than 1.5 litres of water daily |   |   |   |   |   |
| My diet includes a wide variety of foods each week |   |   |   |   |   |
| I eat mostly whole, unprocessed food |   |   |   |   |   |
| I eat at least 5 servings of vegetables daily |   |   |   |   |   |
| I include a source of protein in every meal |   |   |   |   |   |
| I eat 1–2 serves of fruit most days |   |   |   |   |   |
| I see food as something to enjoy, not fear |   |   |   |   |   |
| I am in tune with my body’s hunger and fullness cues |   |   |   |   |   |
| Over the past 12 months I have been on a diet (Always, Tried, Maybe, None) |   |   |   |   |   |
| I have large gaps between meals |   |   |   |   |   |
| I get angry at myself for eating “bad” food |   |   |   |   |   |
| I am in good health to do regular physical activity |  |  |  |  |  |
| I do some form of activity weekly (walking, yoga, Pilates, etc) |  |  |  |  |  |

Please mark your answer with x.

|  |  |  |
| --- | --- | --- |
|   | Yes | No |
| Do you get cold hands and feet in warm rooms and summer? |   |   |
| Do you have hair loss? |   |   |
| Is it easy to put on weight and hard to lose it? |   |   |
| Are your fingernails brittle, ridged, or weak? |   |   |
| Do you get cramps in your muscles? |   |   |
| Do you have outer eyebrow thinning? |  |  |
| Do you have an irregular heartbeat? |   |   |
| Do you have osteoporosis or osteopenia? |   |   |
| Do you have low energy levels? |   |   |
| Have you been diagnosed with Hashimoto or Reidel disease? |   |   |
|   | Yes | No |
| Do you sweat very little or not at all? |   |   |
| Do you have visible or palpable swelling in the front of your neck? |   |   |
| Are you currently taking thyroid medication? |   |   |
| Do you have a puffy face/eyes: Swelling around eyes or cheeks (like "moon face")? |  |  |
| Do you have Depression or persistently low mood? |  |  |
| Do you have Anxiety or panic symptoms? |  |  |
| Do you have Slowed speech or mental sluggishness? |  |  |
| Do you have Low libido or anorgasmia? |  |  |
| Do you have Goitre or visible neck swelling? |  |  |
| Do you have High LDL cholesterol or triglycerides despite good diet? |  |  |
| Do you have difficulty losing weight despite diet/exercise? |  |  |
| Do you experience exhaustion unrelieved by sleep? |  |  |
| Do you have infrequent bowel movements (≤3x/week)? |  |  |
| Do you have dry, thickened skin: Rough patches on elbows, knees, or heels? |  |  |
| Did you have your Gallbladder removed? |  |  |
| Do you have a scalloped tongue? |  |  |
| Do you have low blood pressure (systolic below 118)? |  |  |
| Do you experience shortness of breath or difficulty taking a deep breath? |  |  |
| Do you have Sleep apnoea/snoring? |  |  |
| Do you crave salt or salty foods? |   |   |
| Do you feel lightheaded or dizzy when standing up quickly? |   |   |
| Do you get headaches or migraines around ovulation or before your period? |   |   |
| Do you suffer from heavy or painful periods? |   |   |
| Do you experience bloating or breast tenderness before your period? |   |   |
| Do you have acne that worsens around ovulation or your period? |   |   |
| Do you have unwanted hair growth on your face, chest, or belly? |   |   |
| Do you feel extremely tired the week before your period? |   |   |
| Do you get irritable or moody before your period? |   |   |
| Do you wake at night in the second half of your cycle? |   |   |
| Do you experience hot flushes or night sweats? |   |   |
| Do you have vaginal dryness or low libido? |   |   |
| Have you been diagnosed with fibrocystic breasts or breast lumps? |  |  |
| Is your cycle regular (within 24–35 days)? |   |   |
| Do you spot after intercourse? |   |   |
| Do you skip periods or go >60 days without one? |   |   |
| Have you had any surgeries affecting your uterus, cervix, or ovaries? |   |   |
| Do you require painkillers for period cramps? |   |   |
| Have you ever confirmed ovulation via blood test or scan? |   |   |
| Do you feel nauseated when taking fish oil or B vitamins? |   |   |
| Do you feel bloated or full in the upper right abdomen after fatty meals? |   |   |
| Are your stools pale, floaty, or difficult to flush? |   |   |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|   | Yes | No |
| Have you had gallstones? |   |   |
| Have you had gallbladder removal? |  |  |
| Do you feel puffy, congested, or have swollen lymph nodes regularly? |  |  |
| Do you have a coated tongue or bad breath in the morning? |   |   |
| Do you wake regularly between 1–3 a.m.? |   |   |
| Do you get itchy skin (especially hands/feet) without a rash? |   |   |
| Do you bruise easily or have spider veins? |   |   |
| Are you sensitive to perfumes, cleaning agents, smoke, or strong smells? |   |   |
| Do your PMS symptoms (mood swings, breast tenderness, bloating) last longer than 5 days? |   |   |
| Do you feel worse when starting new supplements? |   |   |
| Do sulfur-rich foods like eggs, garlic, or onions cause gas or discomfort? |   |   |
| Do you feel bloated after meals or throughout the day? |   |   |
| Do you feel overly full after small meals? |   |   |
| Do you see undigested food in your stool? |   |   |
| Do you experience foul-smelling gas or stools? |   |   |
| Do you experience constipation or incomplete evacuation? |   |   |
| Do you alternate between constipation and diarrhea? |   |   |
| Do you experience loose stools after fatty meals? |   |   |
| Do you feel worse after taking probiotics? |   |   |
| Do you crave sugar or carbs strongly and often? |   |   |
| Do you have a coated tongue or bad breath? |   |   |
| Do you grind your teeth? |   |   |
| Do you have anal itching at night? |  |  |
| Do you get rashes, eczema, or acne that worsens after eating? |   |   |
| Do you react negatively to gluten, dairy, or legumes? |   |   |
| Do you regularly take ibuprofen, aspirin, or NSAIDs? |   |   |
| Do meat-heavy meals feel like they ‘sit’ in your stomach for hours? |   |   |
| Did your digestive issues start after a bout of food poisoning or gastro?” |   |   |
| Have you taken antibiotics more than twice in the past 2 years? |   |   |
| Do your wounds take a long time to heal? |   |   |
| Do you have dry, itchy, or inflamed skin? |   |   |
| Do you suffer from hay fever, seasonal allergies, or asthma? |   |   |
| Do you experience chronic sinus issues, congestion, or post-nasal drip? |   |   |
| Do you get rashes, hives, or swelling after eating certain foods? |   |   |
| Do you flush easily or get red face/ears after wine, fermented foods, or chocolate? |   |   |
| Have you ever had mono (Epstein-Barr) or chronic viral infections? |  |  |
| Have you ever had Lyme disease? |  |  |
| Have you had severe black mold exposure? |  |  |
| Do you often feel anxious, overwhelmed, or tense during the day? |   |   |
| Do you find it difficult to wind down or fall asleep at night due to a busy mind? |   |   |
| Do you feel physical tension (jaw, shoulders, gut) on a regular basis? |   |   |
| Do you often feel low, flat, or like you're “just getting by”? |   |   |
| Do you feel hopeless, powerless, or stuck in your fertility journey? |   |   |
| Do you feel guilty when resting, saying no, or prioritising your own needs? |   |   |
|   | Yes | No |
| Do you tend to eat emotionally or use food to comfort yourself? |   |   |
| Do you find it hard to rest, relax, or be still? |   |   |
| Do you feel disconnected from your body, emotions, or intuition? |   |   |
| Have you experienced trauma, betrayal, or loss that still affects you emotionally? |   |   |
| Do you feel unsafe or out of control around your fertility outcomes or menstrual cycle? |   |   |
| Do you have regular emotional or spiritual support from others? |   |   |
| Do you feel short of breath or dizzy during mild activity? |   |   |
| Do you have cracks at the corners of your mouth or pale lips/tongue? |   |   |
| Do you feel tired even after a full night’s sleep? |   |   |
| Have you been told you’re low in Vitamin B12 or folate? |   |   |
| Have you been told you’re anemic or low in ferritin? |  |  |
| Do you get muscle cramps, twitches, or restless legs? |   |   |
| Do you feel sensitive to noise, light, or touch? |   |   |
| Do you have white spots on your nails? |   |   |
| Do you get frequent infections or catch colds easily? |   |   |
| Do your taste and smell seem less sharp than they used to be? |   |   |
| Do you sweat excessively or feel sensitive to heat? |   |   |
| Do you feel irritable, anxious, or overwhelmed before your period? |   |   |
| Do you have PMS with breast tenderness, bloating, or mood swings? |   |   |
| Do you experience brain fog or poor memory? |   |   |
| Do you struggle with fertility despite no clear diagnosis? |   |   |
| Do you eat little or no eggs, liver, seafood, or grass-fed meat? |   |   |
| Have you ever been told you have MTHFR or another gene mutation? |   |   |
| Do you have dry eyes, dry skin, or poor night vision? |   |   |
| Do you have gum issues or frequent bleeding when brushing your teeth? |   |   |
| Do you sunburn easily or feel worse in the winter months? |   |   |
| Have you had frequent miscarriages or trouble with implantation? |   |   |
| Do you have a history of low Vitamin D or osteoporosis in the family? |   |   |
| Do you often crave sugar or carbohydrates instead of savory foods? |   |   |
| Did you ever have Covid? |  |  |
| If yes, do you feel fully recovered, or do symptoms linger (e.g., fatigue, brain fog, immune shifts)? |  |  |
| Did you receive a Covid Vaccination? |  |  |
| Did you receive more than 2 Covid Vaccinations? |  |  |
| Did your menstrual cycle or energy change afterward? |  |  |
| Do you ever experience numbness, tingling, or pins and needles in your extremities? |   |   |
| Are your fingers or toes ever discolored (blue, purple, red, or white)? |   |   |
| Do you notice swelling in your ankles or legs, especially after sitting or standing? |   |   |
| Do you feel lightheaded or dizzy when standing up quickly? |   |   |
| Any history of fainting or near-fainting? |   |   |
| Do you get frequent headaches, migraines, or pressure behind your eyes? |   |   |
| Do you experience “brain fog” or poor memory and concentration? |   |   |
| Do you get visual disturbances or see “floaters”? |   |   |
| Have you ever had retinal changes, blurred vision, or eye pressure? |   |   |

Please provide any additional information you feel is necessary for our consultation below:

**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.