360° Health Care

Confidential Fertility Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

Name _____ Date _____

Date of birth _____ Age _____ Gender: ❍ Male ❍ Female

Address _____ City _____

Province _____ Postal code _____

Phone: Home _____ Work _____ Other _____

May we leave messages relating to your visit? ❍ Yes ❍ No

Email _____

Other health care providers (Medical Doctor, specialists, chiropractors, etc.)

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Emergency contact person

Name: _____ Relationship: _____

Phone: _____ Alternate number: _____

❍ Referral from _____ ❍ Chatelaine ❍ Today's Parent

❍ Internet search ❍ Yellow Pages ❍ Other _____

Would you like to receive our seasonal newsletter with information on health and upcoming events? Your email address will not be shared. ❍ Yes ❍ No

Menstrual History

Age at which menses began _____

Are your periods painful? ❍ Yes ❍ No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? ❍ Light ❍ Normal ❍ Heavy

What colour is the blood? ❍ Light red ❍ Red ❍ Dark red ❍ Purple ❍ Brown ❍ Black

Is there clotting? ❍ Yes ❍ No

Do you have premenstrual tension or emotional problems? ❍ Yes ❍ No

Do you experience acne breakouts before or during your period? ❍ Yes ❍ No

Do your breasts become tender premenstrually? ❍ Yes ❍ No

Do you bleed or spot between periods? ❍ Yes ❍ No

Are your menstrual cycles spaced irregularly? ❍ Yes ❍ No

How many days are there from one period to the next? _____

Date of last menstrual period _____

Pregnancy History

	Number	Year(s)
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Gynecological History

Have you ever had an abnormal Pap smear? ❍ Yes ❍ No

Have you ever had a cervical biopsy, operation, cauterization or conization? ❍ Yes ❍ No

Have you ever had a sexually transmitted infection (STI)? ❍ Yes ❍ No

Do you get yeast infections regularly? ❍ Yes ❍ No

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Have you ever been diagnosed with a chlamydial infection? ❍ Yes ❍ No

Do you have chronic vaginal discharge? ❍ Yes ❍ No

Do you have any sores on your genitalia? ❍ Yes ❍ No

Have you ever had pelvic inflammatory disease? ❍ Yes ❍ No

Were you treated for it? ❍ Yes ❍ No How? _____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? ❍ Yes ❍ No

Have you ever been diagnosed with endometriosis? ❍ Yes ❍ No

Have you been diagnosed with pelvic adhesions? ❍ Yes ❍ No

Have you been diagnosed with any pelvic abnormalities? ❍ Yes ❍ No

Please list all current medications, including dosage, duration of use and reason for use.

Medication	Dose	Duration	Reason/ condition treating

Please list all past prescription medications

_____

_____

_____

Please list all natural health products (supplements, vitamins, herbs, homeopathics).

Natural Health Product	Dose	Duration	Reason/ condition treating

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Ovulatory History

Have your cycles changed since they began? ❍ Yes ❍ No

How? _____

Do you ovulate on your own? ❍ Yes ❍ No

On what day of your cycle? _____

Do your breasts get tender at/ during ovulation? ❍ Yes ❍ No

Do you get premenstrual low back pain? ❍ Yes ❍ No

Do your bowel movements become loose at the beginning of your period? ❍ Yes ❍ No

Fertility History

Have you had any fertility treatments? ❍ Yes ❍ No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? ❍ Yes ❍ No

When? _____ How long? _____

Have your fallopian tubes been evaluated medically? ❍ Yes ❍ No

What were the results? _____

Have you had any tubal operations? ❍ Yes ❍ No

Have you had any hormone laboratory tests performed? ❍ Yes ❍ No

What were the results? _____

_____

Have you taken oral contraceptives? ❍ Yes ❍ No

When? _____ How long? _____

Have you ever had an IUD? ❍ Yes ❍ No

When? _____ How long? _____

Have you ever taken DepoProvera? ❍ Yes ❍ No

When? _____ How long? _____

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Partner's Fertility History

Do you have a single partner with who you have been trying to conceive? ❍ Yes ❍ No

How long have you been married or living together? _____

Has he had a fertility workup? ❍ Yes ❍ No

What were the results? _____

Is your partner supportive of your wish to conceive? ❍ Yes ❍ No

General Health History

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ❍ Yes ❍ No

What was it? _____

How is your sexual energy? ❍ Low ❍ Normal ❍ High

Do you douche regularly? ❍ Yes ❍ No

With what? _____

Do you use vaginal lubricants? ❍ Yes ❍ No

Are you more than 20% over your ideal body weight? ❍ Yes ❍ No

Are you more than 20% below your ideal body weight? ❍ Yes ❍ No

Do you exercise regularly? ❍ Yes ❍ No

Do you have excessive facial hair? ❍ Yes ❍ No

Do you have excessively oily skin? ❍ Yes ❍ No

Have you experienced loss of head hair? ❍ Yes ❍ No

Have you noticed discharge from your nipples? ❍ Yes ❍ No

How would you rate your stress levels? ❍ Overwhelming ❍ High ❍ Moderate ❍ Low

Have you been exposed to any known environmental toxins or hormones? ❍ Yes ❍ No

Do you regularly use any of the following?

❍ Antacids ❍ Aspirin/ Tylenol/ Advil ❍ Birth control pills ❍ Diet pills ❍ Laxatives

❍ Alcohol – form and amount/ day _____

❍ Caffeine – form and amount/ day _____

❍ Tobacco – form and amount/ day _____

❍ Recreational drugs – what and how often? _____

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