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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

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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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Review of Systems

For the following list of symptoms, indicate with a "✔" for those that you currently experience, or "**p**" for those that you've had in the past:

SKIN:
- ❑ rashes
- ❑ eczema
- ❑ psoriasis
- ❑ vitiligo
- ❑ dryness
- ❑ hives
- ❑ acne
- ❑ warts

HEAD:
- ❑ head injury
- ❑ headaches/migraines
- ❑ vertigo/dizziness
- ❑ hair loss
- ❑ dandruff

EYES:
- ❑ redness
- ❑ excessive tearing
- ❑ double/blurred vision
- ❑ spots/floaters
- ❑ flashing lights
- ❑ glaucoma
- ❑ cataracts
- ❑ discharge/infection

EARS:
- ❑ infection
- ❑ ringing in ears (tinnitus)
- ❑ hearing loss

NOSE & SINUSES:
- ❑ frequent colds
- ❑ nasal stuffiness
- ❑ loss of smell
- ❑ nose bleeds
- ❑ chronic runny nose
- ❑ sinus infections
- ❑ nasal polyps

MOUTH & THROAT:
- ❑ bleeding gums/gingivitis
- ❑ sores in mouth
- ❑ thrush
- ❑ enlarged lymph glands
- ❑ torticollis/stiff neck

RESPIRATORY:
- ❑ cough
- ❑ wheezing
- ❑ asthma
- ❑ bronchitis
- ❑ pneumonia
- ❑ emphysema
- ❑ coughing up blood
- ❑ tuberculosis

CARDIOVASCULAR:
- ❑ rapid heart beat
- ❑ high blood pressure
- ❑ chest pain
- ❑ palpitations
- ❑ heart murmurs
- ❑ rheumatic fever
- ❑ difficult breathing
- ❑ leg cramps
- ❑ deep leg pain/ thrombophlebitis
- ❑ edema/swollen ankles
- ❑ cold hands/feet
- ❑ hot flashes

GASTROINTESTINAL:
- ❑ trouble swallowing
- ❑ nausea or vomiting
- ❑ regurgitation/heartburn
- ❑ indigestion
- ❑ bloating
- ❑ abdominal pain
- ❑ excessive passing of gas
- ❑ ulcer
- ❑ hypoglycemia
- ❑ diabetes
- ❑ jaundice
- ❑ hepatitis
- ❑ colitis / Crohn's disease
- ❑ constipation
- ❑ blood in stool
- ❑ diarrhea
- ❑ hemorrhoids
- ❑ eating disorder

GENITO-URINARY:
- ❑ urgency
- ❑ dribbling / leaking
- ❑ frequency
- ❑ incontinence
- ❑ burning/pain on urination
- ❑ urinary tract infections
- ❑ kidney infection
- ❑ kidney stones
- ❑ sexually transmitted diseases (HPV, etc)

GENERALS:
- ❑ noticeable weight loss
- ❑ noticeable weight gain
- ❑ fatigue
- ❑ night sweats
- ❑ profuse perspiration
- ❑ weakness

FEMALE:
- ❑ PMS
- ❑ menopause
- ❑ low libido
- ❑ yeast infection/vaginitis
- ❑ vaginal dryness
- ❑ painful periods
- ❑ irregular periods
- ❑ excessive discharge
- ❑ miscarriage(s)
- ❑ pregnancy(s)
- ❑ abortion
- ❑ endometriosis
- ❑ uterine fibroids
- ❑ cervical dysplasia
- ❑ fibrocystic/breast problems

MALE:
- ❑ BPH/enlarged prostate
- ❑ prostatitis
- ❑ discharge
- ❑ low libido/erectile dysfunction

HAEMATOLOGICAL:
- ❑ anemia
- ❑ easy bleeding
- ❑ easy bruising
- ❑ varicose veins/spider veins
- ❑ any past blood transfusions
- ❑ hepatitis A, B or C
- ❑ HIV

MUSCULOSKELETAL:
- ❑ muscle pains
- ❑ joint pains
- ❑ osteoarthritis
- ❑ back pain
- ❑ muscle spasms/cramps
- ❑ joint swelling
- ❑ gout

NEUROLOGICAL:
- ❑ fainting/black outs
- ❑ numbness/loss of sensation
- ❑ tremors/involuntary movements
- ❑ tingling/ "pins & needles"
- ❑ loss of balance
- ❑ paralysis
- ❑ speech problems
- ❑ memory loss
- ❑ loss of sleep
- ❑ nervousness/tension
- ❑ irritability
- ❑ depression