Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
p: 403-547-2243, e: drshannon@calgarynaturopathiccare.com

Men's Fertility Intake

Name: _____ Today's Date: _____
(First) (Last) dd / mm / yy

Date of Birth: ___/___/____ Gender: F M Age: _____
dd/ mm / yy Other:_____
Preferred pronoun:_____

Height:_____ Weight:_____

Home Address: _____

Town/ City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____

May we leave messages on your home phone relating to your visits? Y N

Emergency contact: _____ Phone:( )_____

Email Address: _____

Family Physician: _____ Phone:( )_____

Other Health Care Provider(s):
Name: _____ Phone: ( )_____
Name: _____ Phone: ( )_____

Partner details:

Name:			
DOB:			
Height:		Weight:	

How many months have you been trying to get pregnant and/or having unprotected sex?_____

Have you ever conceived with this partner before? Y N
Have you ever conceived with a different partner? Y N

Please list number and approximate years of any previous of the following:
Miscarriages:_____
Full term deliveries:_____
Elective terminations (abortions):_____

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Please check off any fertility tests or procedures you have received in the past:

☐ Blood tests

☐ Ultrasounds

☐ ICSI

☐ IUI

☐ IVF

Please check off and describe any of the following that apply to you:

When was your most recent physical exam?	
Below normal sexual energy or libido	
Undescended testicle	
Varicocele	
Urologic surgeries	
Erectile dysfunction	
Difficulty ejaculating	
Exposure to environmental toxins or hormones	
Marijuana use	
Regular bicycle use	
Regular hot tub use	
Any current or previous experience of penile discharge	
Regular nocturnal emission	
Diagnosed with high cholesterol	
Current or past prostate conditions	
Urinary infection	
Sexually transmitted infections	
History of testosterone supplementation or drugs	
Recent blood testosterone level check	
Tested for blockage of reproductive tract	

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Any other fertility testing - sperm count - sperm motility - sperm morphology - DNA fragmentation	

Social History

How many caffeinated beverages do you drink per day?_____
Do you smoke cigarettes? Y N
If yes, how many per day?_____
Do you drink alcohol? Y N
If yes, how many drinks per week?_____
Do you use marijuana? Y N
Do you use any other recreational drugs? Y N

Occupation:_____

Does your job involve physical labour? Y N

How would you describe your stress level relating to work on a scale of 1-10, 1 being the least stress possible and 10 being the most?_____

Do you exercise? Y N
How many times per week?_____
What type of exercise?_____

Mental and Emotional Health

How would you describe your stress level relating to fertility and other life stressors on a scale of 1-10, 1 being the least stress possible and 10 being the most?_____

Do you see a counsellor? Y N
Do you attend a support group? Y N

Have you been diagnosed with or experienced any of the following?

☐ Depression

☐ Anxiety

☐ Other mental illness: _____

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In your opinion, why are you having trouble conceiving?

Thank you for taking the time to fill out this form!

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Consent

Naturopathic Medicine is the treatment and prevention of diseases using natural therapies and treating the person as a whole, and as an individual. Naturopathic doctors use many modalities and therapies that are used to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, and may do a screening physical examination, including a breast exam and may suggest labs or copies of lab work completed by your medical doctor.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication, supplements or over the counter drugs. Inform your Naturopathic doctor of any changes to these. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

As a patient it is your right to receive information about your diagnosis as well as treatment, including treatment alternatives, costs, benefits, risks, adverse effects, and consequences of not treating. As with any form of medical treatment, there are some risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from injections or acupuncture

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee of $0.10 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all possible risks and complications. With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please Print) _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Naturopathic Doctor: _____

Please ensure to give at least 2 hours cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on within two hours or missed appointments, 100% of the cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Naturopathic doctor. Please be aware that phone calls and emails outside of appointments are for clarification purposes only, beyond this is subject to additional consultation fees.

I, _____ (Name), understand and accept the above policies and associated fees.

Signature: _____ Date:_____