

Women'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:	

Pregnancy History

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

Have you been pregnant before? (circle one) Y N

Please list number and approximate years of any previous of the following:

Miscarriages: _____

Tubal/ectopic pregnancies: _____

Full term deliveries: _____

Comments:

Elective terminations (abortions): _____

Menstrual History

Age at first period: _____

Cycle pattern (check all that apply)

- Irregular periods
- Regular periods
- Spotting before periods
- Bleeding between periods
- Heavy periods
- Light periods

Date of first day of last menstrual period? _____

How many days between the first day of one period to the first day of the next period (cycle length)?

If you have an irregular cycle, how many periods do you get a year? _____

How many days of flow? _____

What colour is your menstrual blood?

- Light red
- Bright red
- Dark red
- Purple
- Brown

Do you have clots in the menstrual blood? Y N

If you experience menstrual pain, how many days of pain do you experience? _____

How would you describe your menstrual pain?

- None or less than most people
- About average
- More than average
- Severe pain

Where do you feel the pain? _____

Have you ever had to miss school or work because of your menstrual pain? Y N

Have you been diagnosed with endometriosis in the past? Y N

Have your cycles changed? If so, how? _____

Do you experience any PMS symptoms? _____

Sexual History

How often are you having intercourse? _____
Have you ever used ovulation predictor kits? If so, for how long? _____
Have you ever used basal body temperature to predict ovulation? If so, for how long? _____
Do you use lubricants during intercourse? Please describe? _____

Do you have pain during intercourse? Y N
If yes, please circle: Always Sometimes Yes, but rarely

Have you ever been treated for any of the following sexually transmitted infections?

- Chlamydia
- Gonorrhea
- Syphilis
- Genital warts (HPV)
- Genital herpes (HSV)
- HIV/AIDS
- Other. Please describe _____

What types of contraception have you used in the past?

- Condoms
- Oral birth control pill
- IUD (copper/hormonal)
- Depo Provera
- Withdrawal
- Rhythm method
- Other: _____

Any complications with any contraceptive method? If yes, please describe:

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: _____

Reproductive Health History

When was your last PAP smear? _____
What were the results? (circle one) Normal Abnormal Unknown
Have you ever been treated as the result of an abnormal PAP? Y N
If yes, which procedure? _____

Have you ever had a mamogram or breast ultrasound? Y N
If yes, what were the results? _____

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

- Blood tests
- Ultrasounds
- Cycle monitoring
- Laparoscopy
- Sonohysterogram
- Hysterosalpingogram (HSG)
- Hysteroscopy
- Drugs for ovulation
- ICSI
- IUI

IVF

Are you allergic to any medications? _____

Other allergies? _____

What medications, herbal/nutritional supplements, vitamins, or homeopathics are you taking? _____

Are you taking a prenatal? Y N

If yes, which brand? _____

Are you taking folic acid? Y N

If yes, what dose and which brand? _____

Have you been diagnosed with any medical conditions? _____

Have you been immunized for measles, mumps and rubella? _____

Have you been immunized for chicken pox or had it in the past? Y N

Do you know your blood type? _____

Review of Relevant Symptoms

General	Current	Past
Recent weight gain or loss		
Disordered eating		
Lack of energy		
HEENT	Current	Past
Lack of sense of smell		
Headaches		
Blurred vision		
Hearing loss/deafness		
Respiratory	Current	Past
Asthma		
Tuberculosis		
Hormonal	Current	Past

General	Current	Past
Diabetes		
Hair loss		
Thyroid problems		
Autoimmune condition		
Breasts	Current	Past
Discharge		
Lumps		
Cancer		
Breast reduction		
Breast augmentation/implants		
Skin	Current	Past
Acne		
Excessive hair growth		
Genitourinary	Current	Past
Bladder infections		
Vaginal infections		
Frequent urination		
Leaking urine		
Blood in urine		
Blood	Current	Past
Clotting disorder		
Easy bruising		
Sickle cell anemia		
History blood transfusion		
Cardiovascular	Current	Past
Palpitations		
Heart attack		

General	Current	Past
Stroke		
High blood pressure		

Surgical History

Have you had any surgeries? Y N

Year	Surgery

Family Medical History

Have any of your family members had difficulty conceiving? Y N

Are you aware of any of the following conditions in your family? Answer maybe if you aren't sure, but it's a possibility. Please also indicate the degree of relative if known (mother, aunt, cousin, paternal grandfather etc)

Condition	Yes	Maybe
Birth defects		
Blood clots before age 50		
Bloom syndrome		
Breast cancer before age 50		
Canavan Disease		
Colon cancer before age 50		
Cystic fibrosis		
Deafness/blindness		
Diabetes before age 50		
Down syndrome		
Dwarfism		
Endometriosis		

Condition	Yes	Maybe
Familial Dysautonia		
Fanconi anemia		
Galactosemia		
Heart defect from birth		
Heart disease before age 50		
Hemochromatosis		
Hemophilia		
High blood pressure before age 50		
Infertility (any cause)		
Marfan syndrome		
Menopause before age 40		
Muscular dystrophy		
Neural tube defects		
Niemann-Pick disease		
Ovarian cancer before age 50		
Polycystic kidney disease		
Sickle cell anemia		
Tay-Sachs disease		
Thalassemia		
Thyroid conditions		
Other (please specify)		

In your opinion, why are you having trouble conceiving?

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

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: _____