Rooted… 93 Bell Farm Rd. unit 103 705.792.6717

Naturopathic Medicine
FERTILITY INTAKE FORM

PERSONAL INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex/gender: _____

Home Address: _____

City: _____ Postal Code: _____

Home Telephone: _____ Other Telephone: _____

What number may we leave messages at? _____

Email address: _____
(would you like to be included in our e-mail list? Yes No)

Emergency contact: _____ Phone: _____

Has any other family member already been a client of this clinic? _____

How did you find out about us? (please check all that apply)

☐ Yellow Pages ☐ Friend Whom should we thank?_____
☐ Webpage ☐ Professional referral Whom should we thank? _____
☐ OAND ☐ Other

Health Care Team:
Family Physician: _____ Phone: _____

Other Health Care Providers: _____ Phone: _____

Date of last physical exam:_____ Blood tests done? Y N

Do you get regular screening tests done by a doctor? (Pap, blood, etc.) Y N

What *three* expectations do you have from *this visit* to our clinic?
1. _____
2. _____
3. _____

What *long term* expectations do you have from working with our clinic?
1. _____
   _____
2. _____
   _____

CHIEF HEALTH CONCERNS: What are your health concerns in order of importance

_____

_____

_____

_____

_____

ENVIRONMENT AND LIFESTYLE

Occupation: _____Hours per week: _____

Do you exercise regularly? Y N
What types: _____ How often? _____

Who sincerely and consistently supports you in a positive and beneficial way? _____
_____

Do you: ☐ Live alone ☐ Live with partner ☐ Live with friends ☐ Children ☐ Other_____

How would you describe the emotional climate of your home?_____

What causes you the most stress/worry in life? _____
_____

How do you manage your stress? (include positive and negative ways)_____
_____

What are you hobbies, what do you love to do? _____

_____

MEDICAL HISTORY TIMELINE

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions.
Indicate below any **accidents, broken bones, falls, illnesses, hospitalization, surgeries, CT's, MRI's, X-rays,** and note any emotional circumstances such as **deaths, loss of jobs, marriage, divorces, abuse, addictions, etc.**

Age	Event (stress, accident, imaging, illness, etc)
1-5	
5-10	
10-15	
15-20	
20-25	
25-30	
30-35	
35-40	
40-45	
45-50	
50-55	
55-60	
60-65	
65-70	
70-80	
80-90	

HEALTH HISTORY:
Do you have any allergies (foods, environmental, medications)? Please List

Allergy	What problems do they give you? Diarrhea, stuffy nose, anaphylaxis, etc.	How often are you exposed? Daily, weekly, monthly, etc.	When did you first become aware of the allergy/problem?

Please list all current **prescription medications**:

Name of medication	Dose	Frequency	Duration	Side effects (if any)

Please list all **vitamins, herbs, homeopathics, and non-prescription medications** that you take on a regular basis:

Name and Brand	Dose	Frequency	Duration	Side effects (if any)

Approximately how many times per year have you been treated with antibiotics?
As a child? _____ As an Adult? _____

How often do you use the following:

	Per day	Per week	Per Month
Caffeine			
Cigarettes			
Diet pills			
Pain Relievers			
Sleeping pills/aids			
Antacids			
Laxatives			
Alcohol			
Recreational Drugs			
Fast Food			

Do you follow any special dietary plans? (Religious, vegetarian, vegan, etc.)

_____

_____

List any foods that you crave or make you feel better:

Food/drink the you crave	Approximately how often do you have them? (daily, weekly, etc.)

GENERAL HISTORY:

(For the following list of symptoms: √ for currently experiencing and P for those you've had in the past)

SKIN:
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Vitilago
- ❑ Dryness
- ❑ Hives
- ❑ Boils
- ❑ Acne
- ❑ Warts
- ❑ Recent moles
- ❑ Skin cancer
- ❑ Change in skin texture

HEAD:
- ❑ Head injury
- ❑ Headaches/Migraines
- ❑ Vertigo/Dizziness
- ❑ Hair loss
- ❑ Dandruff
- ❑ Change in hair texture

EYES:
- ❑ Redness
- ❑ Excessive tearing
- ❑ Double/Blurred vision
- ❑ Spots/floaters
- ❑ Flashing lights
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Discharge/infection
- ❑ Eye strain
- ❑ Eye pain

EARS:
- ❑ Infection
- ❑ Ringing
- ❑ Hearing loss

NOSE & SINUSES:
- ❑ Frequent colds
- ❑ Nasal stuffiness
- ❑ Loss of smell
- ❑ Nose bleeds
- ❑ Nasal polyps
- ❑ Sinus infections
- ❑ Chronic runny nose
- ❑ Peculiar smells

MOUTH & THROAT:
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Periodontal disease
- ❑ Thrush
- ❑ Sore throat
- ❑ Enlarged lymph nodes
- ❑ Torticollis/stiff neck
- ❑ Peculiar tastes
- ❑ Production of mucus

RESPIRATORY:
- ❑ Cough
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Emphysema
- ❑ Coughing blood
- ❑ Tuberculosis
- ❑ Central chest pain

CARDIOVASCULAR:
- ❑ Rapid heart beat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Palpitations
- ❑ Heart murmurs
- ❑ Rheumatic fever
- ❑ Difficult breathing
- ❑ Leg cramps
- ❑ Thrombophlebitis
- ❑ Edema/swollen ankle
- ❑ Cold hands/feet

INTESTINAL
- ❑ Trouble swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn/regurgitation
- ❑ Indigestion
- ❑ Bad breath
- ❑ Bloating
- ❑ Abdominal pain
- ❑ Excessive gas
- ❑ Ulcer
- ❑ Hypoglycemia
- ❑ Diabetes
- ❑ Jaundice/hepatitis
- ❑ Colitis or Crohn's
- ❑ Constipation
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Eating disorder

GENITOURINARY:
- ❑ Urgency
- ❑ Dribbling/leaking
- ❑ Frequency
- ❑ Incontinence
- ❑ Burning pain
- ❑ Urinary tract infections
- ❑ Kidney infections
- ❑ Kidney stones
- ❑ STDs (HPV, etc.)

GENERALS:
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fatigue
- ❑ Night sweats
- ❑ Profuse perspiration
- ❑ Weakness
- ❑ Insomnia/poor sleep

FEMALE:
- ❑ PMS
- ❑ Menopause
- ❑ Low libido
- ❑ Yeast infections
- ❑ Vaginal dryness
- ❑ Painful periods
- ❑ Irregular Periods
- ❑ Heavy periods
- ❑ Excessive discharge
- ❑ Miscarriage(s)
- ❑ Pregnancy(s)
- ❑ Abortion(s)
- ❑ Birth control use
- ❑ Abnormal PAP results
- ❑ Endometriosis
- ❑ Uterine Fibroids
- ❑ Fibrocystic breasts

MALE:
- ❑ Enlarged prostate
- ❑ Prostatitis/infection
- ❑ Discharge
- ❑ Low libido
- ❑ Erectile dysfunction

HAEMATOLOGICAL
- ❑ Anemia
- ❑ Easy bleeding
- ❑ Easy Bruising
- ❑ Varicose/spider veins
- ❑ Past transfusions
- ❑ Hep. A, B, or C
- ❑ HIV

MUSULOSKELETAL
- ❑ Muscle pains
- ❑ Joint pains
- ❑ Osteo-arthritis
- ❑ Back pain
- ❑ Muscle spasms/cramps
- ❑ Joint swelling
- ❑ Gout

NEUROLOGICAL:
- ❑ Fainting/Black-outs
- ❑ Numbness
- ❑ Tremors
- ❑ Pins & needles
- ❑ Loss of balance
- ❑ Paralysis
- ❑ Speech problems
- ❑ Memory loss
- ❑ Loss of sleep
- ❑ Nervousness/tension
- ❑ Irritability
- ❑ Depression

WEIGHT:

_____

HEIGHT:

_____

FAMILY HEALTH HISTORY:

Please indicate if a close relative (parent, grandparent, or sibling) has had any of the following)

	Mother	Father	Sibling	Grandparent	Aunt/uncle
Allergies					
Arthritis					
Asthma					
Autoimmune Disease					
Cancer					
Diabetes					
Digestive Disorders					
Heart Disease					
High Blood Pressure					
Mental Illness					
Multiple Sclerosis					
Stroke					
Tuberculosis					
Macular degeneration					
Glaucoma					
Thyroid conditions					
other					

Is there anything else that you would like to add but weren't sure where it fit?

_____

_____

_____

_____

FERTILITY HISTORY

How long have you been trying to conceive? _____
How many pregnancies have you had? And when? _____
If you miscarried, how far were you? _____
Have you had any D&C's preformed? _____
Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Y N
Have you used any fertility medications yet? Y N
If yes, what did you use and for how long _____
_____

Have you had…

- ❑ Abnormal PAP smear
- ❑ A venereal disease
- ❑ Diagnosis relating to infertility
- ❑ Infertility treatments
  When?_____
  Where?_____
  What?_____
- ❑ Changes in cycle since they began
  How?_____
- ❑ Medication to help you ovulate
  When?_____
  How long?_____
- ❑ Medical evaluation of fallopian tubes
  Results?_____
- ❑ Hormone laboratory tests
  Results?_____
- ❑ IUD
  When?_____
  How long?_____
- ❑ Oral contraceptives
  When?_____
  How long?_____
  What brand?_____
- ❑ DepoProvera
  When?_____
  How long?_____
- ❑ Medications for gynecological conditions other than conraceptives

Do you have…

- ❑ Excessive facial hair
- ❑ Excessive oily skin
- ❑ Loss of head hair
- ❑ Discharge from nipples
- ❑ Chronic vaginal discharge
- ❑ Sores on your genitalia

Do you…

- ❑ Ovulate on your own
  What day of cycle?_____
- ❑ Douche regularly
  With what?_____
- ❑ Use vaginal lubricants
- ❑ Get yeast infections regularly

Section #1

Do you have low back weakness, soreness, or pain, or knee problems?	□	
Do you have ringing in your ears or dizziness?	□	
Is your hair prematurely grey?	□	
Do you have vaginal dryness?	□	
Do you have dark circles around or under your eyes?	□	
Do you have night sweats?	□	
Do you frequently need to drink fluid?	□	
Do you have difficulty getting a good quality sleep?	□	
Are you prone to hot flashes or flushing?	□	
Would you describe yourself as restless or anxious?	□	/10

Section #2

Do you have lower back pain pre-menstrually?	□	
Is your low back sore or weak?	□	
Are your feet cold, especially at night?	□	
Do you often feel lethargic?	□	
Do you feel “puffy” or are you prone to gaining weight?	□	
Are you typically colder than those around you?	□	
Is your libido low?	□	
Are you often fearful?	□	
Do you urinate frequently, and is the urine diluted and/or profuse?	□	
Do you have profuse vaginal discharge?	□	
Does your menstrual blood tend to be dull in colour?	□	
Do you feel cold cramps during your period that respond to a heating pad?	□	/12

Section #3

Are you prone to emotional depression?	□	
Are you prone to anger and/or rage?	□	
Do you become irritable pre-menstrually?	□	
Do you feel bloated or irritable around ovulation?	□	
Are you breasts sensitive/sore at ovulation?	□	
Do you experience nipple discharge or pain?	□	
Do you have a lot of premenstrual breast distension or pain?	□	
Have you been diagnosed with elevated prolactin levels?	□	
Do you become bloated pre-menstrually?	□	
Do you have difficulty falling asleep at night?	□	
Do you experience heartburn or wake up with a bitter taste in your mouth?	□	
Are your menses painful?	□	
Is the menstrual blood thick and dark, or purplish in colour?	□	/13

Section #4

Are you often fatigued?	□	
Do you have poor appetite?	□	
Is your energy lower after a meal?	□	
Do you feel bloated after a meal?	□	
Do you crave sweets?	□	
Do you have loose stools, abdominal pain, or digestive problems?	□	
Are your hands and feet cold?	□	
Are you prone to feeling heavy or sluggish?	□	
Do you bruise easily?	□	
Do you have varicose veins?	□	
Are you lacking strength in your arms and legs?	□	
Are you lacking in exercise?	□	
Are you prone to worry?	□	
Have you been diagnosed with low blood pressure?	□	
Do you sweat a lot without exerting yourself?	□	
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	□	
Is your menstruation thin, watery, profuse, or pinkish in colour?	□	
Are you more tired around ovulation or menstruation?	□	
Do you ever spot a few days or more before your period comes?	□	
Have you ever been diagnosed with uterine prolapse?	□	
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	□	
Are you often sick, or do you have allergies?	□	/22

Section #5

Are your menses scanty and/or late?	□	
Do you have dry, flaky skin?	□	
Are you prone to getting chapped lips?	□	
Are your fingernails or toenails brittle?	□	
Are you losing hair on your head (not in patches, but all over)?	□	
Is your hair brittle or dry?	□	
Do you have diminished night time vision?	□	
Do you get dizzy or light-headed around your period?	□	
Are you lips, the inner side of your lower eyelid, or tongue pale in colour?	□	/9

Section #6

Is your menstrual flow ever brown or black in colour?	□	
Do you feel mid-cycle pain around your ovaries?	□	
Do you have painful, unmoveable breast lumps?	□	
Do you experience periodic numbness of your hands and feet (especially at night)?	□	
Do you have varicose or spider veins?	□	
Do you have chronic haemorrhoids?	□	
Does your menstrual blood contain clots?	□	
Have you been diagnosed with endometriosis or uterine fibroids?	□	
Can you feel any abnormal lumps in your lower abdomen?	□	
Do you have piercing or stabbing menstrual cramps?	□	
Do you have dark spots in your eyes?	□	
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	□	/12

Section #7

Do you wake up early in the morning and have trouble getting back to sleep?	□	
Do you have heart palpitations, especially when anxious?	□	
Do you have nightmares?	□	
Do you seem low in spirit or lacking vitality?	□	
Are you prone to agitation or extreme restlessness?	□	
Do you fidget?	□	
Do you sweat excessively, especially on your chest?	□	/7

Section #8

Is your pulse rate rapid?	□	
Are your mouth and throat usually dry?	□	
Are you thirsty for cold drink most of the time?	□	
Do you often feel warmer than those around you?	□	
Do you wake up sweating or have hot flashes?	□	
Do you break out with red acne (especially premenstrually)?	□	
Do you have a short menstrual cycle?	□	
Do you have vaginal irritation or rashes?	□	/8

Section #9

Do you feel tired and sluggish after a meal?	□	
Do you have fibrocystic breasts?	□	
Do you have cystic of pustular acne?	□	
Do you have urgent, bright, or foul-smelling stools?	□	
Does your menstrual blood contain stringy tissue or mucus?	□	
Are you prone to yeast infections and vaginal itching?	□	
Do your joints ache, especially with movement?	□	
Are you overweight?	□	/9

Section #10

Do you have the majority of symptoms in section #8 and/or #9?	□	
Do you have foul-smelling, yellow, or greenish vaginal discharge?	□	
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	□	/3

Section #11

Do you have the majority of symptoms in section #2?	□	
Do you have the majority of symptoms in section #6?	□	
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	□	/3