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FERTILITY INTAKE FORM

Successful healthcare and preventive medicine require a healthy relationship between provider and patient. The nature of your responses to the following questions will significantly contribute to your doctor's understanding of you and your health history on many important levels. Your time, thoughtfulness, and honesty will help both of us to begin an appropriate course of treatment that is tailored to your needs and goals. Thank you!

PERSONAL INFORMATION:

Name _____ *Date of Birth* _____ *Age* _____

Partner's Name _____ *Date of Birth* _____ *Age* _____

Address _____

City _____*State* _____ *Postal Code* _____

Phone # home _____ *mobile* _____ *Phone # (wk)* _____

Okay to leave a message re: appointments? _____*Email* _____

Occupation _____ *Hours per week* _____ *Employer* _____

Emergency contact _____ *Relation?* _____ *Phone:* _____

How did you hear about our clinic? (If a friend or other provider referred you, please let us know specifically who).

_____

Aside from fertility, do you have any other primary concerns for seeking naturopathic care? If you have a specific health condition for which you are seeking treatment, please describe it in detail.

_____
_____
_____
_____

Please list ***any other*** *health concerns (physical, emotional or mental) in order of importance:*

_____
_____
_____

Name of current ***general practitioner*** *(MD):*_____ *Phone* _____

List other ***health professionals*** *you are seeing and include their area of practice (e.g. Massage).*

_____*(Ph)*_____

_____*(Ph)*_____

_____*(Ph)*_____

How do you rate your overall health? POOR FAIR AVERAGE GOOD EXCELLENT
How do you rate your overall energy? POOR FAIR AVERAGE GOOD EXCELLENT

Current Weight ____ Height ____ Wt. 1 yr ago ____ Max. adult Wt. ____ Min. adult weight _____

MEDICATIONS:
Please list all current medications (prescription and over-the counter):

Medication	*Dose/day*	*How long?*
1.		
2.		
3.		
4.		

Approximately how many times have you taken antibiotics? _____

Have you had an adverse reaction to a medication? NO/YES List the Medication: _____

Please circle if you have taken any of the following within the last year, or around puberty:

Antibiotics: Aminoglycosides Minocin Nitrofurantoin Sulfasalzine Other

Antidepressants of any kind Antihistamines Blood pressure medications or ACE inhibitors

Anti-inflammatories: Advil/ Motrin Aspirin Tylenol Naproxen / Aleve Vioxx Celebrex

Cough medications or decongestants Psychiatric Medications/ Sleeping meds Clomid/ Letrozole

Antifungals Chemotherapy agents Migraine medications

PARTNER: Is your partner taking any medications, or has he within the last year? Please list here:

_____

ALLERGIES:

List all (to medications, pollens, foods, animals etc.):

_____

NATUROPATHIC REMEDIES:
List all naturopathic remedies (herbal, vitamin/mineral, nutritional, homeopathic etc.) you are taking:

1.	*5.*
2.	*6.*
3.	*7.*
4.	*8.*

CHILDHOOD MEDICAL HISTORY:

*Please **CIRCLE** if you have had any of the following childhood **illnesses:***

Asthma	*Measles*	*Rheumatic fever*
Chicken pox	*Mumps*	*Diptheria*
Scarlet fever	*Mono (how long? _____)*	*Tuberculosis*
Eczema	*Polio*	*Whooping cough*
Frequent ear infections/colds	*Rubella (German measles)*	*Other: _____*

IMMUNIZATIONS: *(**CIRCLE** all the vaccinations that you have had)*

DPT HAEMOPHILUS INFLUENZA B HEPATITIS A HEPATITIS B
MMR TETANUS CHICKEN POX SMALLPOX
POLIO FLU SHOT OTHER: _____

Any adverse reactions to a vaccination? Briefly describe if applicable:

_____

Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations.

_____
_____

FAMILY HISTORY:
Please indicate whether any of your family members have, or have had, the following:

Condition	***Relative***	***Condition***	***Relative***
Alcoholism		*Diabetes*	
Allergies		*Drug abuse*	
Alzheimer's disease		*Heart condition*	
Arthritis		*High blood pressure*	
Asthma		*Kidney disease*	
Cancer (indicate type)		*Osteoporosis*	
Depression		*Stroke*	
Other mental illness		*Suicide*	
Bleeding disorders		*Infertility*	
Glaucoma		*Thyroid Conditions*	

LIFESTYLE FACTORS
Any current dietary restrictions? (vegan, vegetarian, etc.)
_____

How much water do you drink in a day? _____

On average, how many hours of sleep do you get each night? _____ Good Quality? Y / N

Do you exercise? Y / N What type(s) of exercise and what frequency? _____

What do you enjoy for recreation and relaxation?_____

Do you have a religious or spiritual practice you would like us to know about? _____

_____

Do you currently consume any of the following? (Indicate how often, how much and for how long)

Alcohol _____ *Tobacco _____*
Coffee _____ *Soft drinks _____*
Black tea _____ *Marijuana _____*
Laxatives _____ *Other _____*

Are you frequently exposed to animals? Y / N Exposed to toxins or hazards? Y / N, List: _____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (If so place a star next to the event)

1)_____ Date_____
2)_____ Date_____
3)_____ Date_____
4)_____ Date_____
5)_____ Date_____

What is the emotional climate of your home?

_____
_____
_____

*Rate your current stress level (**CIRCLE**): LOW AVERAGE HIGH UNBEARABLE*

*Which factors most contribute to your stress? (**CIRCLE**)*

HEALTH WORK MONEY FAMILY RELATIONSHIP FERTILITY OTHER : _____

MALE REPRODUCTION

Do you have regular annual health screening tests? (blood work, prostate examination) Y / N

Date of last prostate examination? (month/yr) ___ / ___

Do you have any previously diagnosed/ treated STI's? If so, what? _____

Do you have any pain or discomfort with intercourse? _____

Any history of pregnancy with other partners? If yes, how many and were pregnancies carried to term?

_____

Any difficulty with urination? Y / N How often do you urinate at night? _____

*Have you had any of the following? (**CIRCLE**)*
TESTICULAR PAIN HERNIA STIs DISCHARGE SKIN LESIONS

FEMALE REPRODUCTION

Do you get regular PAP smears Y / N *Date of last PAP? (month/year) ____ / ____*

Have you ever had an abnormal PAP? N / Y If so, how was it treated (eg- LEEP) ? _____

Have you ever been pregnant? Y / N
If so, please share how it progressed and the outcome _____

_____

Age of first period? _____ *Is your period regular Y / N*

Length of monthly cycle (eg 28,32)? _____ Average # days of period or flow? (3,5,7) _____

Do you experience PMS? Y / N *Do you have spotting/bleeding between periods? Y / N*

Are you tracking your cycle currently? Y/ N If yes, how? _____

Please circle relevant PMS symptoms:
BLOATING BREAST TENDERNESS IRRITABILITY DEPRESSION
HEADACHES MOOD SWINGS FOOD CRAVINGS OTHER: _____

Past forms of contraception and dates when used _____

Have you ever had a sexually transmitted infection? Y / N

*Have you ever had any of the following concerning your **breasts**? (**CIRCLE**)*
PAIN LUMPS INFECTIONS CYSTS NIPPLE DISCHARGE

Do you experience vaginal infections? NEVER RARELY FREQUENTLY

Do you experience bladder infections? NEVER RARELY FREQUENTLY

Do you have any sexual problems or concerns? N/Y please explain: _____

What expectations do you have of me as your physician?

_____
_____

What expectations do you have from this first visit to our clinic?

_____
_____

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REVIEW OF SYSTEMS

*Please **CIRCLE** if you are **currently** experiencing any of the following symptoms, OR if you have experienced any of these symptoms before write a **"P"** for **Past**.*

GENERAL SYMPTOMS	***EARS/EYES/NOSE/THROAT***	***CARDIOVASCULAR***
Headache	*Dental decay*	*Low Blood Pressure*
Head injury	*Gum disorder*	*High Blood Pressure*
Fever	*Enlarged thyroid*	*Previous Stroke*
Chills	*Tonsillitis*	*Hardening Arteries*
Sweats	*Sore Throat*	*Swelling of Ankles*
Dizziness	*Hoarseness*	*Poor Circulation*
Fainting	*Enlarged Glands*	*Paralytic Stroke*
Loss of Sleep	*Glaucoma*	*Irregular Heart Beat*
Fatigue	*Failing vision*	*Shortness of Breath*
Nervousness/Anxiety	*Cataracts*	*Chest Pain*
Loss of Weight	*Eye Pain*	
Numbness/pain (extremeties)	*Ear discharge*	***GASTROINTESTINAL***
Allergies	*Deafness*	*Bloating*
Convulsions	*Hay Fever*	*Excessive thirst*
Depression	*Mercury dental fillings*	*Excessive hunger*
	Ear ache	*Reflux*
SKIN	*Nasal Discharge*	*Eating Disorder*
Change in mole(s)	*Nose bleeds*	*Belching*
Hives / allergic reactions	*Nasal obstruction*	*Gas (flatulence)*
Acne / skin eruptions	*Sinus Infection*	*Nausea*
Itching (ears, skin, rectum)		*Vomiting*
Bruising easily	***MUSCLE & JOINT***	*Vomiting of blood*
Dryness	*Fracture/dislocation*	*Abdominal Cramps*
Boils	*Stiff neck*	*Constipation*
Varicose veins	*Back pain*	*Diarrhea*
Sensitive skin	*Muscle weakness*	*Hemorrhoids*
	Swollen joints	*Liver problems*
KIDNEYS/REPRODUCTIVE	*Painful tailbone*	*Jaundice*
Prostate inflammation	*Foot problems*	*Gallbladder issues*
Genital lesions	*Pain in shoulders*	*Irritable Bowel syndrome*
Inability to control urine	*Hernia*	*Crohn's Disease*
Frequent urination	*Spinal curvature*	*Ulcerative Colitis*
Painful urination	*Poor posture*	
Blood in urine	*Arthritis*	***RESPIRATORY***
Pus in urine		*Asthma*
Kidney infection		*Difficulty breathing*
Kidney stones		*Chronic cough*
Erectile dysfunction		*Spitting up phlegm*
Infertility		*Spitting up blood*

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

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