Docere Wellness Centre

Your path to optimal wellness starts here.

Fertility Intake Questionnaire

This form is confidential, and kept in your file. Please fill this form out as accurately as possible.

Name:
_____

Address:
_____

City: _____ Postal Code: _____

Phone numbers: (H) _____ (W) _____

Email: _____ Age: _____ Date of birth (MM/DD/YY): _____
Sex:__

Who referred you to us? _____

Would you like to receive email newsletters from our clinic? _____

Would you like to receive appointment reminders through e-mail? _____

Primary Fertility and Health Concerns: Please list in order of importance to you

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

Physician's Diagnosis (if available): _____

Are you currently undergoing medical fertility treatment? ___ Yes ___ No

If Yes: Clinic name: _____ Doctor's name: _____

___ Cycle Monitoring plus Timed Intercourse ___ Natural IUI ___ Medicated IUI

___ IVF ___ Donor Egg IVF ___ Other: _____

Are you receiving other alternative/natural treatment(s)? ___ Yes ___ No

If Yes:
___ Massage Therapy ___ Acupuncture ___ Chiropractor ___ Bowen Therapy

___ Naturopath ___ Herbalist ___ Homeopath ___ Nutritionist

____Cranio Sacral ___ Other: _____

Have you had acupuncture before? ___ Yes ___ No

Please list all medications (prescription and over the counter) you are currently taking:

Please list all nutritional supplements, vitamins, herbs and/or homeopathics currently taking:

Do you have allergies? ___ Yes ___ No

If Yes, please list your allergies:

Please list any hospitalizations due to infections, injury, or chronic illness, including the diagnosis, year of occurrence and treatment (antibiotics, surgery, etc.)

Lifestyle: Please **CIRCLE** all that apply

Coffee/Tea/Pop – Number of cups/cans/bottles per week _____/_____/____

Chocolate/Sweets/Desserts – Number of times per week _____

White flour products (Bread, pasta, crackers, etc.) – Number of servings per week _____

Vegetables (All kinds) – Number of servings per day/week _____/_____

Fast food/Junk food – How often per week _____

Water – Cups per day _____

Exercise: Number of times per week _____ Type of exercise: _____

Sleep, average no. of hours/night _____ Quality of sleep: poor / fair / good / excellent

Cigarettes/cigars – Number per week _____ Recreational drugs – No. of times per week _____

Alcohol – Wine (Red/White) / Beer / Spirits / Other Number of drinks per week _____

Are you a vegetarian? _____ If yes: ___ Lacto / Ovo ___ Fish is allowed ___ Vegan

Bowel Movements: Number of times per day/week _____ Difficulty passing stool? _____

Any digestive problems? (gas, bloating, etc.) ___ If yes, please detail:

Is your appetite:

___ Normal ___ Tendency to overeat ___ Tendency to under-eat

___ Need to eat frequently

Height: _____ Weight: _____

Which of the following medications are you taking now or have taken in the past?

___ Antacids	___ Antibiotics	___ Anti-Inflammatories	___ Anti-Histamines
___ Aspirin	___ Birth Control Pill	___ Pain Relievers	___ Laxatives
___ Cortisone	___ Sleeping Pills	___ Thyroid Meds	___ Tranquilizers

Other (Please list) _____

Please tell us more about yourself, what you like best about yourself, what you like least. What are your greatest fears, your hopes, and your goals in life? (You may be scratching your head over this one, but it gives insight into how best to design your treatment plan, especially with regard to lifestyle changes. A few sentences are fine, or feel free to continue on to the back of this page.)

Has any blood relative had or currently has: (Indicate relationship to you)

Alcoholism _____ Allergies _____

Asthma _____ Arthritis _____

Cancer _____ Diabetes _____

Epilepsy _____ Fertility Issues _____

Heart Disease _____ High Blood Pressure _____

Kidney Disease _____ Mental Illness _____

Migraines _____ Strokes _____

Syphilis or Gonorrhea _____ Tuberculosis _____

FEMALES:

Age at first menstruation? ____ years old
Length of cycle (i.e. 28 days)? _____ How many days is your menses? _____

Is your cycle: ___ Regular ____ Irregular ____ Often Early ____ Often Late

Do you spot or bleed outside your normal flow? ____ Yes ____ No

If yes: ____ Mid-cycle ____ Before start of period ____ End of period

Describe your flow? ____ Heavy ___ Light ___ Average

Colour of blood? ___ Pink ___ Bright Red ___ Dk Red ___ Purple ___ Brown ___ Black

Consistency of blood? ___ Watery/thin ___ Average ___ Thick ___ Mucus in blood

Do you have clots during menses? ____ Yes ___ No
If yes, when during the period? ___ Start ___ Middle ___ End
What size are the clots? ____ Large ____ Small

Do you experience pain during your menses? ___ Yes ___ No If yes, when in your cycle?

___ Before period starts ___ During & What days? (i.e.days 2 & 3) _____ ___ After

Type of pain? ___Stabbing ___Dull ___On & Off ___Cramping ___Heavy ___Downward

Does anything relieve the pain? (i.e. pressure, cold, heat) _____

Do you experience nipple sensitivity or discharge? ___ Yes ___ No

Do you experience PMS? ___ Yes ___ No If yes, check all that apply:

___ Breast tenderness ___ Cramps ___ Acne ___ Change in bowel movements
___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___ Fatigue ___ Poor Sleep

Other PMS symptoms you experience _____

Is there a change in your energy or fatigue around your menses? (more energy/fatigue)
___ Before ___ During ___ After ___ No change

Do you ever feel colder during your menses? ____ Yes ___ No
Do you ever feel warmer during your menses? ____ Yes ___ No

Do you ovulate on your own? ___ Yes ___ No

If yes, when do you ovulate? [Which cycle day(s)?] Day(s) _____

Are your breasts tender during ovulation? ___ Yes ___ No

Do you experience pain around ovulation? ___ Yes ___ No

Does your libido increase around ovulation? ___ Yes ___ No

Do you see cervical mucous around time of ovulation? ___ Yes ___ No

Quality of mucous (check all that apply): ___ Stretchy ___ Clear ___ Slippery
___ Yellow streaks ___ White ___ Crumbly, Dry ___ Lotiony ___ Cheesy
Other _____

Have you been on Birth Control Pills? ___ Yes ___ No
How long? _____ When did you stop? _____
Have you ever had an IUD? ___ Yes ___ No For how long? _____
Have you ever taken Depo-Provera? ____ Yes ___ No

Do you experience vaginal discharge or secretions? ___ Yes ___ No
Colour: ___ White ___ Yellow ___ Green ___ Pink ___ Red
Consistency: ___ Watery ___ Thick ___ Sticky ___ Crumbly
Odour: ___ Normal ___ Unpleasant ___ Metallic ___ Foul

Please check if you use any of the following to track your ovulation cycle:

___ Basal Body Temperature Charts ___ Ovulation sticks ___ Salivary fering device

Have you been exposed or received chemotherapy or radiation? ___ Yes ___ No

How is your sexual desire (mental interest)? ___ Low ___ Normal ___ High

How is your sexual arousal (physical arousal/orgasm)? ___ Low ___ Normal ___ High

Do you use vaginal lubricants? ___ Yes ___ No

Do you have excessive facial/body hair? ___ Yes ___ No Oily skin? ___ Yes ___ No

Have you experienced excessive loss of head hair? ___ Yes ___ No

If you have been pregnant:

How many times have you been pregnant? _____

How many times have you given birth? _____ Ages of children _____

How many miscarriages?____ Weeks pregnant?_____ What year(s)?_____

How many times has a D&C been performed? _____ What year(s)? _____

Any therapeutic abortion(s)? ___ Yes ___ No What year(s)? _____

Were there any complications during or after any of these pregnancies? ___ Yes ___ No

If yes, please provide details:

Date of last Pap smear: _____/_____/_____ (MM/DD/YY)

Have you ever had an abnormal pap? ___ Yes ___ No

Have you ever had a cervical biopsy, operation, &/or cauterization? ___ Yes ___ No

Do you get yeast infections regularly? ___ Yes ___ No

Do you get bladder infections (UTI's) regularly? ___ Yes ___ No

Have you ever been diagnosed with Chlamydia? ___ Yes ___ No

Have you ever had pelvic inflammatory disease (PID)? ___ Yes ___ No
How were you treated for it? _____

Have you ever been diagnosed with:

Uterine Fibroids?	___ Yes ___ No	If yes, when? _____
Uterine Polyps?	___ Yes ___ No	If yes, when? _____
Pelvic adhesions?	___ Yes ___ No	If yes, when? _____
Prolapsed uterus?	___ Yes ___ No	If yes, when? _____
Pelvic abnormalities?	___ Yes ___ No	
Uterine abnormalities?	___ Yes ___ No	
Endometriosis?	___ Yes ___ No	When?_____ Stage? _____
PCOS/PCO	___ Yes ___No	If yes, when? _____

Other: _____

Do you have a single partner with whom you've been trying to conceive? ___ Yes ___ No ___NA

How long have you been married or living together? _____

Are you using donor sperm either because you have a female partner, or you male partner has fertility issues? ___Yes ___ No

How long have you been trying to conceive? _____

Is your partner supportive of your wishes to conceive? ___ Yes ___ No

Have either of you had a western medical diagnosis relating to infertility? ___ Yes ___ No

If yes, what was it? _____ By whom? _____

Have you taken medication to help you ovulate? ___ Yes ___ No

What kind/name? _____ For how many cycles? _____

Have your fallopian tubes been evaluated? ___ Yes ___ No Results? _____

Have you had any tubal operations? ___ Yes ___ No

Hormone laboratory tests performed: (If any)

FSH (Day 3 or if not, what day of cycle? _____) ___ Normal ___ High

Estrogen (Day of cycle? _____) ___ Normal ___ High

Prolactin	___ Normal ___ High
Thyroid (TSH: give the actual value if known: _____)	___ Normal ___ High ___ Low
Progesterone (Day of cycle? _____)	___ Normal ___ High ___ Low
Testosterone	___ Normal ___ High ___ Low
DHEA	___ Normal ___ High ___ Low
Other _____	___ Normal ___ High ___ Low

Please detail fertility treatment history (IUI, IVF, FET, etc.) (Use other side of page if necessary)

Month/Year	Treatment (IUI, IVF, etc.)	Response (No. of follicles, embryos & grades)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments/Notes related to Medical Fertility Treatment:

Sample Diet

Write down all the foods and drinks consumed over the next two days, starting today.

Please add as much information as possible including quantities eaten brand names, and whether the food is fresh or packaged, refined or natural.

Day 1	**Day 2**
Breakfast: _____	Breakfast: _____
Lunch: _____	Lunch: _____
Dinner: _____	Dinner: _____
Snacks/Drinks: _____	Snacks/Drinks: _____

Are these two days representative of your usual eating habits? If not, what is usual?

Breakfast: _____	Dinner: _____
Lunch: _____	Snacks/Drinks: _____