#126, 6104-172 Street
Edmonton AB T6M 1G9
780-489-7799 ~ www.wellness-within.ca

Fertility Intake Form

***Please bring all of the completed forms in this package with you to your first visit.**

Name: ____ Today's date: __________________

Date of Birth: _______/_______/ _________ Age: _______ Gender: Male: ❐ Female: ❐
Month Day Year

Occupation: ____ AHC# ___________________________

Live with: ❐ spouse ❐ partner ❐ children (how many? ______) ❐ roommate ❐ parents ❐ alone

CONTACT INFORMATION

Please inform us if your contact information changes

Address: ____

City: ______________________________ Province: __________ Postal Code: _________________________

Phone (H): _______________________ (Bus.): ______________________ (Cell): _____________________

E-mail: ____

❐ Check here if you would prefer NOT to receive our Wellness e-newsletter

EMERGENCY CONTACT

Name: ____ Relationship: ____________________________

Phone (H): _______________________ (Bus.): ________________________ (Cell):_______________________

HEALTHCARE PROVIDERS:

Primary Health Care Physician: ______________________________________ Phone: ______________________

When was your last physical exam? ____

Are you currently under the care of a specialist? ❐ Y ❐ N

Name: _________________________ Specialty: ___________________________ Phone: ____________________

Are you currently under the care of alternative health care providers? ❐ Y ❐ N

Name: _________________________ Specialty: ___________________________ Phone: ____________________

Name: _________________________ Specialty: ___________________________ Phone: ____________________

FERTILITY & HEALTH CONCERNS

Please list your health concerns, in order of greatest importance to you.

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

Are there any traumatic life events you've experienced (physical/ mental/ emotional) that you feel may be associated with your current health concerns? ____

Are you currently undergoing medical fertility treatment? ❒ Y ❒ N
If Yes:
❒ Cycle monitoring with timed intercourse ❒ Clomid ❒ Natural IUI ❒ Medicated IUI ❒ IVF ❒ Donor Egg IVF
❒ Other: _________________________

Are you currently receiving other alternative or natural treatments for fertility? ❒ Y ❒ N
If Yes:
❒ Massage Therapy ❒ Acupuncture ❒ Chiropractor ❒ Naturopathic ❒ Herbalist ❒ Homeopathy
❒ Craniosacral ❒ Other: _______________________

VITAMINS AND SUPPLEMENTS

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand name)	Total daily dose	Reason for Use	Duration of Use

PRESCRIPTION MEDICATIONS

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

LIFESTYLE

Describe a typical day's diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Water intake (total quantity): ____

Other fluids (what & total quantity): ____

What is the primary source of your drinking water? ❒ Tap ❒ Well ❒ Bottled (spring) ❒ Filtered ❒ Distilled

Is there anything about your diet you would like to change? ____

____

On average how many meals do you eat per day? 1 2 3 4 5 >5

Which is usually your largest meal? ❒ Breakfast ❒ Lunch ❒ Dinner

List any foods that you crave regularly: ____

List any foods you exclude from your diet: ____

Do you follow a specific diet regime? ❒ Vegetarian ❒ Vegan ❒ Other ______________________

Do you consume organic foods? ❒ Never ❒ 1-3x/wk ❒ 3-5x/wk ❒ 5-7x/wk ❒ Daily ❒ Several times/day

Do you monitor your intake of ❒ Fat ❒ Salt ❒ Sugar ❒ Fiber ❒ Carbohydrate ❒ Protein

Any known food allergies/ intolerances/ sensitivities? ______________________________________

Do you experience binge eating or drinking? ❒ Yes ❒ No Compulsive eating? ❒ Yes ❒ No

Any history of nutrient deficiency? (ie. Iron, B12, Folate) __________________________________

What are the major stresses in your life? (i.e. financial, job related, health, family, spiritual)

1.____

2.____

3.____

4.____

Has there been an event or illness from which you have never fully recovered from? ______________________

____

____

Indicate your current stress level on a scale of 1-10: Low 1 2 3 4 5 6 7 8 9 10 High

How do you deal with stress? ________________ Does this approach help sufficiently? ________________

How would you describe your spirituality? ____

What do you do for recreation? (i.e. What are your hobbies and interests?) ___________________________

____

MENSTRUAL CYCLE HISTORY

Age of first menses: _______________ Is your cycle?: ❒ Regular ❒ Irregular ❒ Often Early ❒ Often late
Do you experience? ❒ Heavy Periods ❒ Light Periods ❒ Missed Periods
Length of cycle (time between the onset of one period to the onset of the next): _____________
For how long do you usually bleed on average? _______ days
Do you experience spotting outside of your normal period? ❒ Y ❒ N
If yes, when in your cycle? ❒ Mid-cycle ❒ Before period starts ❒ After period ended
How many pads/ tampons do you use on the heaviest day of your cycle? ___________
Colour of blood? ❒ Pink ❒ Bright Red ❒ Dark Red ❒ Purple ❒ Brown ❒ Black
Consistency of blood? ❒ Watery ❒ Average ❒ Thick ❒ Mucous in blood
Do you experience clots with your period? ❒ Y ❒ N
If Yes, when during the period? ❒ Start ❒ Middle ❒ End
What size of clots? ❒ Dime sized or smaller ❒ Quarter sized ❒ Loonie Sized ❒ Larger
Do you experience pain during your period? ❒ Y ❒ N
If yes, when in your cycle? ❒ Before period starts ❒ After period ended ❒ During Days: ________________________
Type of pain? ❒ Stabbing ❒ Dull ❒ Cramping ❒ Heavy feeling ❒ Downward pressure ❒ On & Off ❒ Severe
Does anything relieve the pain? (pressure, cold, heat, etc) ____
Do you ever feel colder during your period? ❒ Y ❒ N Do you ever feel warmer during your period? ❒ Y ❒ N
Do you experience? ❒ Hot flashes ❒ Night Sweats
Do you experience a change in energy or fatigue around your period? ❒ More Energy ❒ Fatigue ❒ No Change
If Yes, When? (Before, during, after) ____

PMS symptoms:

PMT-A	PMT-C	PMT-D	PMT-H	PMT-P
❒ Nervous Tension	❒ Headache	❒ Depression	❒ Weight Gain	❒ Joint Pain
❒ Irritability	❒ Craving sweets	❒ Forgetful	❒ Abdominal Bloating	❒ Low back pain
❒ Mood Changes	❒ Increased Appetite	❒ Crying	❒ Swelling of extremities	❒ Abdominal pain
❒ Anxiety	❒ Heart pounding	❒ Confusion	❒ Breast Tenderness	❒ Headaches
❒ Insomnia	❒ Dizziness or faint	❒ Clumsy	❒ Water retention	
❒ Paranoia	❒ Fatigue	❒ Withdraw		

OVULATION HISTORY

Do you ovulate on your own? ❒ Y ❒ N ❒ Unsure
Have you taken medications to help you ovulate? ❒ Y ❒ N
If yes, which medication? ____________________________ For how many cycles? ______________________________
Are your breasts tender during ovulation? ❒ Y ❒ N
Do you experience pain around ovulation? ❒ Y ❒ N
Does your libido increase around ovulation? ❒ Y ❒ N
Do you notice increased/watery cervical mucous around time of ovulation? ❒ Y ❒ N
Quality of cervical mucous? (check all that apply) ❒ Stretchy ❒ Clear ❒ Slippery ❒ Yellow ❒ White ❒ Crumbly/Dry
❒ Lotiony ❒ Cheesy ❒ No mucous ❒ Other: _________________________
Any other vaginal discharge or secretions? ❒ White ❒ Yellow ❒ Green ❒ Pink ❒ Red

Odour? ❐ Normal ❐ Unpleasant ❐ Metallic ❐ Foul

Do you use vaginal lubricants? ❐ Y ❐ N Do you experience vaginal dryness? ❐ Y ❐ N

Do you experience yeast infections regularly? ❐ Y ❐ N

Do you use any of the following to track your cycles and ovulation? ❐ Basal Body Temperature ❐ Ovulation/LH sticks ❐ Saliva Ferning ❐ Cervix position

REPRODUCTIVE HISTORY

Date of last PAP: ________________________ Have you ever had an abnormal PAP? ❐ Y ❐ N

If yes, what was abnormal? ____

Have you ever had a cervical biopsy, operation or cauterization? ❐ Y ❐ N

Have you ever been diagnosed with Chlamydia? ❐ Y ❐ N

Have you ever been diagnosed with PID? ❐ Y ❐ N How was it treated? ___________________________________

Have you ever been diagnosed with? ❐ Uterine polyps ❐ Pelvic Adhesions ❐ Prolapsed Uterus ❐ Retroverted Uterus ❐ Endometriosis ❐ Fibroids ❐ PCOS ❐ Ovarian Cysts ❐ Other: ________________________

❐ Pelvic abnormalities If yes, describe: _____________________________

❐ Uterine abnormalities If yes, describe: ____________________________

Have you ever been exposed to Chemotherapy or Radiation? ❐ Y ❐ N

Do you have: ❐ Excessive facial or body hair ❐ Oily Skin ❐ Excessive loss of head hair ❐ Acne ❐ Skin Tags

Do you experience pain with intercourse? ❐ Y ❐ N

How would you describe your libido (sexual desire)? ❐ Low ❐ Normal ❐ High

How would you describe your arousal (physical arousal/orgasms) ❐ Low ❐ Normal ❐ High

Have you had your hormones tested? ❐ Y ❐ N

FSH	Cycle day: _________	❐ Normal	❐ High	❐ Low
LH	Cycle day: _________	❐ Normal	❐ High	❐ Low
Estrogen	Cycle day: _________	❐ Normal	❐ High	❐ Low
Progesterone	Cycle day: _________	❐ Normal	❐ High	❐ Low
Testosterone		❐ Normal	❐ High	❐ Low
Prolactin		❐ Normal	❐ High	❐ Low
Thyroid (TSH)		❐ Normal	❐ High	❐ Low
DHEA		❐ Normal	❐ High	❐ Low
Other: ___________________		❐ Normal	❐ High	❐ Low

Breast Health:

Do you experience:

❐ Fibrocystic breasts ❐ Breast tenderness ❐ Nipple discharge ❐ Skin Puckering

❐ Lump ❐ Dry skin on nipple ❐ Lactation

Are you currently Breastfeeding? ❐ Y ❐ N

Do you perform monthly self-breast exams? ❐ Y ❐ N

Are you familiar with how to perform a self-breast exam? ❐ Y ❐ N

Date of last breast exam: _______________ Do you have regular mammograms? ❐ Yes, how often _____________ ❐ N

Are you using donor sperm either because you have a female partner or your male partner has fertility issues? ❐ Y ❐ N

How long have you been trying to conceive? ____

Is your partner supportive of your wishes to conceive? ❐ Y ❐ N

Do either of you have a medical diagnosis related to infertility? ❒ Y ❒ N

If yes, what diagnosis? ____

Have your fallopian tubes been evaluated (HSG)? ❒ Y ❒ N

Were there any findings (describe) ? ____

Have you had any tubal or pelvic operations? ❒ Y ❒ N If yes, what operation?____________________

Any tubal pregnancies? ❒ Y ❒ N

Please detail fertility treatment history (IUI, IVF, FET, etc)

Month/Year	Treatment type (IUI, IVF, etc)	Response (# of follicles, embryos & grades)
______	__________________	______________________________
______	__________________	______________________________
______	__________________	______________________________
______	__________________	______________________________
______	__________________	______________________________
______	__________________	______________________________

Any family history of infertility? ❒ Y ❒ N

If yes, is the cause known? ____

Any family history of:

❒ Depression or mental illness ❒ Brain Cancers ❒ Birth defects ❒ Heart Disease ❒ Stroke

❒ Heart Attacks ❒ Glaucoma ❒ Pre-Eclampsia ❒ Miscarriages ❒ Autism

❒ Acute Lymphoblastic Leukemia ❒ Blood Clots ❒ Dementia ❒ High Homocysteine

❒ Colon or other GI Cancer ❒ MTHFR mutation

PREGNANCY HISTORY

What types of birth control have you used in the past? ______________________________

Number of: Pregnancies: _____ Abortions: _____ Miscarriages: ______ Live births: ______

If you experienced miscarriages, how many weeks pregnant? ____________________________

How long ago?____

How many times has a D&C been performed? ________________ How long ago? ____________________

Any therapeutic abortions? ❒ Y ❒ N How long ago? __________________________________

Were previous pregnancies conceived naturally? ❒ Y ❒ N

If no, which fertility interventions were used? ______________________________________

Were there any complications during or after any of your pregnancies? ❒ Y ❒ N

If yes, please provide details: ____

Any genetic illnesses or birth defects identified during a pregnancy? ❒ Y ❒ N

If yes, please provide details: ____

MALE PARTNER HISTORY

Have you had a recent physical exam? ❐ Y ❐ N
Any current health conditions? ____

Have you ever been diagnosed with:

❐ Undescended testicle	❐ Varicocele	❐ Prostate Condition	❐ Urinary tract infections
❐ Small or soft testis	❐ Testicular trauma	❐ Hydrocele	❐ Spermatocele
❐ Epidydimitis	❐ Kidney disease	❐ Hernia	❐ Testicular mass

Have you had any urologic surgeries? ❐ Y ❐ N (including vasectomy reversal)

If yes, please provide details: ____

Have you experienced: ❐ Erectile dysfunction ❐ Difficulty ejaculating ❐ Penile discharge ❐ High fever in last 6 mo's

❐ Testicular pain ❐ Low sexual drive

Have you had exposure to environmental toxins or hormones? ❐ Y ❐ N

If yes, please provide details: ____

Have you ever contracted a sexually transmitted infection? ❐ Y ❐ N

If yes, please provide details: ____

Have you had a sperm evaulation? ❐ Y ❐ N If yes, were there any abnormalities found? ❐ Y ❐ N

If yes, please provide details: ____

Sperm count ____________million

Sperm motility ____________%

Sperm Volume ____________ml

How many days of abstinence? ____________

Has sperm DNA fragmentation been checked? ❐ Y ❐ N
If yes, what is the fragmentation %? ____________
Have your testosterone levels been checked? ❐ Y ❐ N If Yes, were levels: ❐ Normal ❐ High ❐ Low
Have you ever taken testosterone supplements or drugs? ❐ Y ❐ N

Were you able to conceive with a female partner in the past? ❐ Y ❐ N

If Yes, how long ago? ____________________

Was there any difficulties conceiving or any complications? ____________________

Additional comments/ Anything you would like to share that hasn't already been covered: ____________________
____
____

How did you hear about our clinic? ____________________

SIGNATURE

I, ____________________ attest that the information provided is true and accurate to the best of my knowledge.

Signature: ____________________ Date: ____________