Riverside Acupuncture & Wellness Centre

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Fertility Intake Form

All information is used to establish a pattern of your health and will be kept strictly confidential.

Please answer in **bold:**

NAME: DATE:

ADDRESS: DATE OF BIRTH AGE:
PLACE OF BIRTH:

Single: OCCUPATION:
Partner's Name:

PHONE - HOME: INSURANCE:
WORK: REFERRED BY:
CELL:
E-MAIL:
FAX: FAMILY DOCTOR:

Smoker: Yes / No Right-handed / Left-handed /Ambidextrous Height:

Pregnant: Yes / No Breast Implants: Yes / No Weight:

Blood Type: A / B / AB / O Positive /Negative

Any Blood borne Infections (eg. Hepatitis, HIV) *Please list*:

REASON FOR CONSULTATION:

When did the problem begin?

To what extent does it interfere with your daily activities?

What kinds of treatments have you tried?

What makes it better? What makes it worse?

Diagnosis by MD:

If you are currently undergoing ART, when (approximately) is your next retrieval date?
MEDICAL HISTORY: Please answer in **bold**.

BIRTH: (anything significant about your birth - prolonged labour, forceps delivery, Caesarian?)

ILLNESS / SURGERIES / ACCIDENTS: (please list in chronological order with age or date and indicate length of time)

CHILDHOOD

ADOLESCENT

ADULT

SCARS: (please include location of all operation or injury scars, even minor ones)

ALLERGIES: *(*drugs, chemicals, foods, environmental, ..)

MEDICAL CHECKUPS:

Date of last:Physical: Fertility testing:

Tests done (blood work, PAP, cholesterol, mammogram, etc.)	Results

VACCINATIONS: (please list your vaccinations with the year that you received them):

FAMILY HISTORY: (all major illnesses in your immediate family members, eg. diabetes, heart disease cancer, asthma, any gynecological disorders, neurological disorders, psychological disorders, orthopedic disorders, etc.)

	Living? - age	Cause of death - age	Health Issues
Mother			
Maternal grandmother			
Maternal grandfather			
Maternal aunts & uncles			
Father			
Paternal grandmother			
Paternal grandfather			
Paternal aunts & uncles			
Sisters			
Brothers			
Children			

MEDICATIONS: (list all prescription & over the counter medications that you are currently taking or have taken in the last 3 years)

Medicine	Dose	Reason

SUPPLEMENTS: (please include all herbs, vitamins, minerals, homeopathic remedies)

LIFESTYLE: Please answer in **bold**.

Occupational stress: (chemical, physical, psychological, etc.)

Is your work: __ very stressful? __ bit stressful? __ not stressful; More ____ physical? ____mental?

Any recent changes in your family life? job? school? diet?

Please describe any regular exercise that you do & how often:

Weight: _____How long have you been at this weight? ______________Does it fluctuate much? _____
Any rapid weight gain or loss? Yes / No

Please describe your average daily diet and the time that you normally eat your meal:
Morning:
Afternoon:
Evening:
Have you ever been on a restricted diet? Yes / No
What is the best thing about your eating habits?

What is the worst thing about your eating habits?

How much water do you drink a day?

How much caffeine do you drink per week? __coffee; __black tea; __green tea; __soft drink; __ other

How much alcohol do you drink per week? __ wine; __ beer: __ liquor: __ other

Do you smoke cigarettes? __yes __no. How much?

Do you use recreational drugs? Yes / No

Have you traveled outside of Canada/USA in the last 10 years? If so, where?

Toxic Exposure: Please list any exposure to toxins (environmental, chemical, electrical, etc) in your work place, home, or elsewhere

Treatment Modalities currently being used:
__ massage; __ chiropractic; __ physiotherapy; __ naturopathy; __ homeopathy; __ acupuncture;
__ colon cleansing;__ herbal medicine; __ cranio sacral; __ other (please describe):

Have you ever been treated by acupuncture before? Yes / No

How do you feel about your:

	Great	Good	OK	Poor	Bad
Family					
Self					
Work					
Sex					
Food					
Relationships					

Do you feel you treat yourself well?

How would you describe your health & emotions as a child?

How would you describe your emotions now?

Which of the following do you sometimes get stuck in? __Worry; __Anger; __Fear; __Grief; __Sadness; __Anxiety; __Joy; __Ecstasy; __Other

Do you have a spiritual / religious belief?

SYMPTOMS: (please answer in **bold**, if you have had any of the following symptoms in the last 3 months)

GENERAL:
__ chills; __ fever; __ tendency to feel warm; __ tendency to feel cold; __ chill easily;
__ day sweats; __ night sweats; __ afternoon fevers; __ cold sweats;
__ sweaty palms, soles or elsewhere *(please identify);* __ facial flushes;
__ constant slight fever; __ never sweat; __ cold hands; __ cold feet; __ cold abdomen;
__ poor balance; __ weight loss; __ general feeling of heaviness in body; __ fatigue;
__sudden energy drop (what time of day?); __ fatigue worse w activity;
__ tired after eating; __ bleed or bruise easily; __ feel better after exercise; __ worse after exercise;
__ often gets colds or flu; __ colds / flu tend to linger for weeks / months;
__ swelling of hands; __ swelling or puffiness around ankles or feet; __ other areas of swelling *(list)*
__ moody in morning; __ tired, low energy in morning, but energetic in evening to midnight;
__ easily affected by weather changes; __ easily get car (sea, air) sick

SKIN:
__ rashes; __ ulcerations; __ hives; __ eczema; __ itching; __ acne; __ recent moles;
__ skin cancer; __ fungal infections; __ warts; __ psoriasis; __ dermatitis; __ Herpes outbreaks;
__ dry skin; __ dandruff; __ hair loss; __ alopecia; __ change in hair or skin texture;
__ other *(please describe)*

HEAD:
__ dizziness; __ dizzy when standing up quickly or standing long time; __ concussions; __ fainting;
__ red face; __ facial flushing;
__ headaches (which area of the head; how often; duration; any particular time of day/week/month)

__ migraines; __ headache with nausea
Describe your headache: __ heavy, tight band; __ throbbing; __ stabbing; __ dull; __ other
What makes your headache better: __ heat; __ cold; __ rest; __ moving around; __ pressing on it;

EENT:
__ poor vision; __ blurry vision; __ night blindness; __ eye strain; __ eye pain;
__ spots in front of eyes; __ sensitive to light; __ floaters/spots; __ red eyes; __ itchy eyes;
__ dry eyes; __ feel pressure in eye; __ cataracts; __ macular degeneration; __ glaucoma;
__ puffiness or darkness around eyes; __ other eye problems;
__ ringing in ears; __ poor hearing; __ hearing loss; __ earaches; __ deafness;
__ frequent ear infections; __ itchy ear; __ear pain;
__ sinus problems; __ nose bleeds; __ sinus headaches; __ stuffy nose; __ mucus *(what colour?);*
__ post-nasal drip; __ constant sinus congestion;
__ recurrent sore throats; __ dry throat; __ dry mouth; __ itchy throat; __ strep throat;
__ copious saliva; __ difficulty swallowing; __ laryngitis; __ bad breath;
__ sores on lips or tongue; __ bleeding, swollen, painful gums; __ periodontitis;
__ stomatitis (inflammation of mouth);
__ grinding teeth; __teeth problems; __ facial pain; __ TMJ; __ jaw clicks;
__ toothaches without cavities; __ other *(please describe)*:

DENTAL WORK:
__ recent dental work (crowns, root canals, fillings, extractions, bridges, etc; please specify & give date)
__ dental abscesses

RESPIRATORY:
__ difficulty breathing; __ asthma; __ pain with deep breath; __ difficulty breathing when lying down;
__ shortness of breath with little exertion; __ emphysema; __ lung abscess; __ wheezing; __ allergies;
__ cough with phlegm (what color) ___________ dry cough; __ bronchitis; __ coughing blood;
__pneumonia; __ other *(please describe)*

CARDIOVASCULAR:
__ high blood pressure; __ low blood pressure; __ irregular heartbeat; __ blood clots; __ phlebitis;
__ fast pulse (over 100 beats/min); __ slow pulse (less than 60 beats/min); __ palpitations; __ anemia;
__ chest pain or stuffiness; __ feeling of pressure in chest; __ other *(please describe)*

HORMONAL BALANCE:
__ hypo-thyroid; __ hyper-thyroid; __ hypoglycemia; __ blood sugar imbalance; __ diabetes;
__ other *(please describe)*

AUTOIMMUNE/INFLAMMATORY
__ allergies *(what type)* __ low immune system;
__ arthritis; __ rheumatism; __ lupus; __ myofascitis; __ fibromyalgia;
__ other *(please describe)*

APPETITE:
__ poor appetite; __ change in appetite; __ always hungry; __ cravings (please describe);
__ peculiar tastes or smells; __ weight gain; __ weight loss; __ no appetite for breakfast;
__ get full after eating small amount; __ distension after eating; __ eat little bits at a time;
__ fatigue after eating; __ hard to gain, lose, regulate weight;
__ strong thirst (for hot? or cold?); __ thirst at night; __ thirsty but don't want to drink;
__ prefer hot food or drinks; __ prefer cold food or drinks; Favourite taste: ;
__ other *(please describe)*

GASTROINTESTINAL:
__ nausea; __ vomiting; __ gas; __ belching; __ indigestion; __ bad breath; __ gurgling in abdomen
__ heartburn; __ ulcer; __ acid reflux; __ lack of stomach acid; __ gastritis; __ anorexia;
Pain in: __ stomach, __ abdomen (below navel), __ around navel, __ under ribs, __ inguinal area;
__ gall bladder stones; __ gall bladder removed; __pancreatitis; __Ileocecal valve

Frequency of bowel movement:_______________________ Does it feel complete Yes / No
__ normal; __ constipation; __ difficulty passing; __ hard; __ dry; __ painful; __ have to strain;
__ burning; __ foul odour;
__ diarrhea or loose stools; __ urgent; __ with undigested food; __ with mucus;
__ alternating constipation & diarrhea; __ blood in stools; __ black stools; __ peritonitis;
__ Irritable Bowel; __ Chron's; __ colitis; __ diverticulosis / itis; __ polyps; __ GI tumours;
__ rectal pain; __ haemorrhoids; __ abdominal pain or cramps; __ chronic laxative use;
__ other *(please describe)*

GENITOURINARY:
Urination - how may times a day ____; __ night urination *(how many times)* ___;
__ frequent urination; __ painful urination; __ burning; __ difficult urination;
__ urinary urgency; __ decrease in flow; __ urinary leakage (eg. when coughing);
__ blood in urine; __ any particular colour to urine?: Clear, Dark, Reddish, Cloudy, Normal *(bold);*
__ dribbling /lack of bladder control; __ weak stream; __ unable to hold urine;
__ urinary incontinence; __ large amount; __ small amount;
__ kidney stones; __ bladder stones; __ sores on genitals; __ bladder prolapse;
__ other *(please describe)*

SLEEP:
__ poor sleep; __ trouble falling asleep; __ don’t feel rested in morning; __ nightmares;
__ trouble staying asleep (any particular time that you wake up?);
__ do you nap regularly; __ do you take sleeping pills; __ other (please describe)
normal bedtime ____ ; normal rising time ______; number of hours of sleep ____

MUSCULOSKELETAL:
Pain in: __ Neck ; __ shoulder; __ hand/wrist ; __ foot ; __ knee; __ hip; __ whole body;
__ upper back; __ mid back; __ low back;
__ muscle weakness; __ muscle pains; __ muscle spasms; __ muscle tension; __ twitching;
__ tendonitis; __ plantar fascitis; __ swelling in joints; __ pain under ribs or diaphragm;
__ sore weak or cold knees;
__ numbness; __ tingling; __ any other muscle, joint or bone problems (please describe)
Better with: __ heat; __ cold; __ pressure; __ rest; __ eating; __ change in weather
Pain feels: __ sharp; __ dull; __ distending; __ burning; __ heavy; __ achey; __ boring;
__ comes & goes

NEUROPSYCHOLOGICAL:
__ seizures; __ dizziness; __ loss of balance; __ lack of co-ordination;
__ mental confusion / disorientation; __ areas of numbness; __ tremors;
__ prone to depression; __ irritable, short temper, easily angered; __ easily stressed; __ fearful;
__ sadness / grief; __ low motivation, lack of will power; __ anxiety or nervousness;
__ difficulty concentrating; __ poor memory; __ mentally sluggish; __ easily overwhelmed by details
__ treated for emotional problems; __ have considered or attempted suicide;
__ other *(please describe)*

WOMEN ONLY:

MENSTRUAL HISTORY: Please answer, check or highlight in **bold**.

Menses:
Age at first menses ___; Length of time between menses___; Duration___;
Date of last menses_______
__ Regular periods; __ Irregular periods; __ Early periods; __ Late periods
__ Breakthrough bleeding between periods; __ Spotting before periods
__ Heavy periods; __ Light periods; __ Clots (large / medium / small)
Colour: __ bright red; __dark red; __brown; __ pale
Painful __ if so - which days of cycle ______________; What age did it start ________________
More tired: __before period starts; __ during period; __ after period; __ no difference
Have your cycle changes since they began? Yes / No; If so, how? ____________________________

PMS:
__ Breast distension; __ Emotional changes ; __ Cramps; __ Bloating; __ Water retention
__ Food cravings; __ Headaches; __ Back pain; __ Acne; __ Loose bowels;
__ Other *(please describe)*

Ovulation:
Do you ovulate on your own? Yes / No; On what day of your cycle
How do you monitor ovulation: __ Urine kit; __ Saliva; __ Basal Body Temperature;
__ Cervical mucus
Can you feel your ovulation? Yes / No; Do your breasts get tender at ovulation? Yes / No

Vaginal Infections:
Do you get yeast infections often? Yes / No;
__ Vaginal discharge (please describe texture & colour); __ Vaginal sores

Breasts:
__ Breast cysts, lumps; __Discharge (clear __; bloody __; milky__)
__ Reduction; __ Implants (silicone __; saline __)
__ Breast cancer; __Other

Menopause:
Symptoms: (please list)

__ Hormone Replacement Therapy

CONTRACEPTIVE HISTORY

__ Birth Control Pill; dates of use:
__ IUD; dates of use:
__ injectable (eg. DepoProvera); dates of use:
__ tubal sterilization; date:
__ other

How many months have you been trying to get pregnant without contraception __

PREGNANCIES

Number of:
Pregnancies__; Births__; Abortions__
Caesarean births __; Premature births__; Stillbirths __
Miscarriages__; at which weeks ___________
Ectopic pregnancies __

SEXUAL HISTORY

__ Pain with intercourse
How would you rate your libido? __low; __ moderate; __high
Do you douche regularly? Yes / No; with what:
Do you use vaginal lubricants? Yes / No

TESTING: (please list any abnormal results w dates)
__ PAP:
__ Mammogram:
__ STDs:
__ Chlamydia:
__ Gonorrhea:
__Syphillis:
__Herpes;
__HPV (genital warts)
__ other

PROCEDURES: (with dates)

__ Cauterization;
__ Cervical biopsy;
__Conization;
__ D&C;
__ Hysterectomy
__ Hysteroscopy
__ Laparoscopy;
__ Tubal ligation
__ Other

GYNECOLOGICAL DISORDERS: (please list dates & any treatment / medication that you took)

__ Amenorrhea
__ Blockage of Fallopian tubes
__ Endometriosis
__ Pelvic Adhesions
__ Pelvic Inflammatory Disease
__ Polycystic Ovary Syndrome
__ Salpingitis
__ Uterine Fibroids / Polyps / Cysts
__ Uterine prolapse
__ Other

FERTILITY HISTORY: Please answer in **bold**.

Have you had fertility treatments? Yes / No
If so - when and where

What tests were run? Please give results of all tests
__ Thyroid

__ Day 3 FSH blood test

__ Hysterosalpingogram

__ Progesterone blood test

__ Prolactin blood test

__ Other

Were you given a diagnosis relating to infertility:

List dates of Fertility procedures with medication protocols that were followed

Please note: As a courtesy, please allow 48 hours notice to cancel or reschedule an appointment; this allows us to reschedule the time for another client. A cancellation or rescheduling of less than 24 hours may result in the full rate being charged.

Signature: ___________________________________ Date:___________________________

MALE ONLY: Please answer in **bold,** those symptoms that pertain to you..

:

___ Feeling of cold in the genitals
___ Impotency
___ Spontaneous emission
___ Diagnosis of infertility
___ Pain or swelling of testicles
___ Premature ejaculation
___ Vasectomy
___ Prostate concerns

Have you had a fertility work-up? ___yes; ___no;

What were the results? (Volume, morphology, morbidity, motility and any other findings).

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Signature: ___________________________________ Date:___________________________