living wellness centre

patient intake form
women's fertility

Date last menses began /

Is your menstrual cycle: ☐ Regular ☐ Irregular

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: ☐ Heavy ☐ Light ☐ Average **Consistency of blood**: ☐ Watery ☐ Thick ☐ Average

Does your blood contain clots? ☐ Yes ☐ No **At which point during the cycle?** ☐ Start ☐ Mid ☐ End

Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc

Do you experience menstrual pain? ☐ Yes ☐ No	☐ Before menses ☐ During _____ (please specify which days) ☐ After
What relieves the pain?	☐ Stabbing ☐ Cramping ☐ Dull ☐ Heavy ☐ On/off

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply. ☐ Fatigue ☐ Night sweats ☐ Sleep disturbances

☐ Breast tenderness ☐ Cramps ☐ Acne ☐ Change in bowel movements ☐ Bloating ☐ Headaches ☐ Nausea ☐ Moodiness

Please list any other pre-menstrual symptoms

Do you ovulate on your own? ☐ Yes ☐ No What Day? _____	Do you chart your cycle? ☐ BBT ☐ Ovulation sticks ☐ Saliva
Do you experience pain around ovulation? ☐ Yes ☐ No	Do your breasts get tender around ovulation? ☐ Yes ☐ No
Do you notice stretchy clear egg white slippery cervical mucus around ovulation? ☐ Yes ☐ No	

How many times have you been pregnant? _____ How many times have you given birth? _____
Ages of children _____ Sex of children _____ Given names _____
Have you had any miscarriages? ☐ Yes ☐ No
If yes, how many, at how many weeks pregnant, and in what year(s)?
_____
How many times have you had a D&C preformed? _____
How many abortions have you had? _____ In what year(s)? _____
Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with:

STD? …….	☐ Yes ☐ No
Pelvic inflammatory disease? ……	☐ Yes ☐ No
Uterine fibroids? ……..	☐ Yes ☐ No
Polyps? …….	☐ Yes ☐ No
Pelvic adhesions? ……	☐ Yes ☐ No
Prolapsed uterus? ……	☐ Yes ☐ No
Unique shape of uterus?	☐ Yes ☐ No
Endometriosis? ……	☐ Yes ☐ No
PCOS (polycystic ovarian syndrome)?...	☐ Yes ☐ No

Date of last pap smear: _____/_____/_____
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
Have you ever had a cervical biopsy or operation? ☐ Yes ☐ No
Do you get yeast infections regularly? ☐ Yes ☐ No
Do you get bladder infections regularly? ☐ Yes ☐ No
If answered yes, list STDs: _____

Do you experience vaginal discharge? ☐ Yes ☐ No
If yes, what colour? ☐ White ☐ Yellow ☐ Green ☐ Pink ☐ Red
If yes, what consistency? ☐ Watery / thin ☐ Thick ☐ Sticky
If yes, does it have foul odour? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No
For how long? _____ **When did you stop?** _____
Have you ever had an IUD? ☐ Yes ☐ No
Have you ever taken Depo-Provera? ☐ Yes ☐ No

Have you had any hormone testing done? (e.g., Day 3, Day 21)

FSH ……..	☐ Low	☐ Normal	☐ High
Estrogen (E2) ……..	☐ Low	☐ Normal	☐ High
Progesterone ……..	☐ Low	☐ Normal	☐ High
Prolactin ……..	☐ Low	☐ Normal	☐ High
Thyroid (TSH) ……..…	☐ Low	☐ Normal	☐ High
Testosterone ……	☐ Low	☐ Normal	☐ High
Other: _____	☐ Low	☐ Normal	☐ High

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Do you currently have a partner? ☐ Yes ☐ No
If yes, what is your partner's name? _____
Are you married or living together? _____ For how long? _____
Is your partner supportive of your wishes to conceive? _____

How long have you been trying to conceive? _____

Have you had a Western medical diagnosis relating for fertility? ☐ Yes ☐ No
If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? ☐ Yes ☐ No
If yes, what was the diagnosis? _____ Who made the diagnosis? _____

Have you taken medication to help you ovulate? ☐ Yes ☐ No
If yes, what kind? _____ For how many cycles? _____

Have you had your uterine/fallopian tubes evaluated medically (HSG)? ☐ Yes ☐ No
What were the results? _____

Have you had any tubal operations? ☐ Yes ☐ No

Have you ever undergone assisted reproductive treatments? (IUI, IVF, ICSI superovulation, etc) ☐ Yes ☐ No

Month/Year	Type of treatment	Clinic	Results

What was your medical response to the fertility treatments? ☐ Poor ☐ Average ☐ Good

Are you using donor sperm? ☐ Yes ☐ No
If yes, why? (no partner, female partner, male partner has semen issues, etc.) _____

Are you using donor eggs or embryos? ☐ Yes ☐ No

How is your sexual desire (mental interest)?..... ☐ Low ☐ Normal ☐ High
How is your sexual arousal (physical/orgasm)?..... ☐ Low ☐ Normal ☐ High
Do you use vaginal lubricants?..... ☐ Yes ☐ No
Have you been exposed to or received chemotherapy or radiation? … ☐ Yes ☐ No
Do you have excessive facial or body hair? …….. ☐ Yes ☐ No
Do you have excessively oily skin? ……. ☐ Yes ☐ No