Dr. Shannon Ferguson, ND
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# Women's Fertility Intake

Name: ________________________________________ Today's Date: _______________
(First) (Last) dd / mm / yy

Date of Birth: ___/___/____ Gender: F M Age: ______
dd/ mm / yy Other:_______________
Preferred pronoun:_________

Height:___________ Weight:____________

Home Address: _________________________________________________________

Town/ City: _____________________________ Postal Code: _________________

Home Telephone: ( ) __________________ Work: ( ) _________________

Email Address: _________________________________________________________

May we leave messages on your home phone relating to your visits? Y N

Emergency contact: _________________________ Phone:( )_______________

Family Physician: ___________________________ Phone:( )_______________

Other Health Care Provider(s):
Name: _______________________________________ Phone: ( )______________
Name: _______________________________________ Phone: ( )______________

Partner details:

| Name: | | | |
|---|---|---|---|
| DOB: | | | |
| Height: | | Weight: | |

**Pregnancy History**

How many months have you been trying to get pregnant and/or having unprotected sex?____________________

Have you been pregnant before? (circle one) Y N

Please list number and approximate years of any previous of the following:
Miscarriages:_______________________________________________________________
Tubal/ectopic pregnancies:___________________________________________________
Full term deliveries:__________________________________________________________

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| Comments: |
| --- |
| |

Elective terminations (abortions):________________________________________________

**Menstrual History**
Age at first period: _______________

Cycle pattern (check all that apply)

☐ Irregular periods
☐ Regular periods
☐ Spotting before periods
☐ Bleeding between periods
☐ Heavy periods
☐ Light periods

Date of first day of last menstrual period?__________________
How many days between the first day of one period to the first day of the next period (cycle length)?
______________________________
If you have an irregular cycle, how many periods do you get a year? ___________________
How many days of flow?__________________
What colour is your menstrual blood?

☐ Light red
☐ Bright red
☐ Dark red
☐ Purple
☐ Brown

Do you have clots in the menstrual blood? Y N

If you experience menstrual pain, how many days of pain do you experience?_______________
How would you describe your menstrual pain?

☐ None or less than most people
☐ About average
☐ More than average
☐ Severe pain

Where do you feel the pain?________________________________________________________________________________________
________________________________________________________________________________________________
Have you ever had to miss school or work because of your menstrual pain? Y N

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Have you been diagnosed with endometriosis in the past? Y N

Have your cycles changed? If so, how?______________________________________________________________________
______________________________________________________________________

Do you experience any PMS symptoms?______________________________________________________________________
______________________________________________________________________

**Sexual History**

How often are you having intercourse?___________________

Have you ever used ovulation predictor kits? If so, for how long? __________________

Have you ever used basal body temperature to predict ovulation? If so, for how long?_____________________

Do you use lubricants during intercourse? Please describe?______________________________________

Do you have pain during intercourse? Y N

If yes, please circle: Always Sometimes Yes, but rarely

Have you ever been treated for any of the following sexually transmitted infections?

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Genital warts (HPV)
- ☐ Genital herpes (HSV)
- ☐ HIV/AIDS
- ☐ Other. Please describe _____________________

What types of contraception have you used in the past?

- ☐ Condoms
- ☐ Oral birth control pill
- ☐ IUD (copper/hormonal)
- ☐ Depo Provera
- ☐ Withdrawal
- ☐ Rhythm method
- ☐ Other:______________________________________________________________

Any complications with any contraceptive method? If yes, please describe:

______________________________________________________________________
______________________________________________________________________

**Social History**

How many caffeinated beverages do you drink per day?_________

Do you smoke cigarettes? Y N

If yes, how many per day?__________________

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Do you drink alcohol? Y N
If yes, how many drinks per week?__________________
Do you use marijuana? Y N
Do you use any other recreational drugs? Y N

Occupation:________________________________________________________________________

Does your job involve physical labour? Y N

How would you describe your stress level relating to work on a scale of 1-10, 1 being the least stress possible and 10 being the most?_________________

Do you exercise? Y N
How many times per week?________________
What type of exercise?____________________

**Mental and Emotional Health**
How would you describe your stress level relating to fertility and other life stressors on a scale of 1-10, 1 being the least stress possible and 10 being the most?_________________

Do you see a counsellor? Y N
Do you attend a support group? Y N

Have you been diagnosed with or experienced any of the following?

- ☐ Depression
- ☐ Anxiety
- ☐ Other mental illness: _________________________________

**Reproductive Health History**
When was your last PAP smear?______________________________
What were the results? (circle one) Normal Abnormal Unknown
Have you ever been treated as the result of an abnormal PAP? Y N
If yes, which procedure? ____________________________

Have you ever had a mamogram or breast ultrasound? Y N
If yes, what were the results?_________________________

Please check off any fertility tests or procedures you have received in the past:

- ☐ Blood tests
- ☐ Ultrasounds
- ☐ Cycle monitoring
- ☐ Laparoscopy
- ☐ Sonohysterogram
- ☐ Hysterosalpingogram (HSG)
- ☐ Hysteroscopy
- ☐ Drugs for ovulation
- ☐ ICSI
- ☐ IUI

☐ IVF

Are you allergic to any medications?______________________________________________
Other allergies?__________________________________________________________
What medications, herbal/nutritional supplements, vitamins, or homeopathics are you taking?__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Are you taking a prenatal? Y N
If yes, which brand?_____________________________
Are you taking folic acid? Y N
If yes, what dose and which brand?_____________________________

Have you been diagnosed with any medical conditions?___________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Have you been immunized for measles, mumps and rubella?______________________________
Have you been immunized for chicken pox or had it in the past? Y N

Do you know your blood type?__________________

**Review of Relevant Symptoms**

| General | Current | Past |
|---|---|---|
| Recent weight gain or loss | | |
| Disordered eating | | |
| Lack of energy | | |
| **HEENT** | **Current** | **Past** |
| Lack of sense of smell | | |
| Headaches | | |
| Blurred vision | | |
| Hearing loss/deafness | | |
| **Respiratory** | **Current** | **Past** |
| Asthma | | |
| Tuberculosis | | |
| **Hormonal** | **Current** | **Past** |

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| General | Current | Past |
|---|---|---|
| Diabetes | | |
| Hair loss | | |
| Thyroid problems | | |
| Autoimmune condition | | |
| **Breasts** | **Current** | **Past** |
| Discharge | | |
| Lumps | | |
| Cancer | | |
| Breast reduction | | |
| Breast augmentation/implants | | |
| **Skin** | **Current** | **Past** |
| Acne | | |
| Excessive hair growth | | |
| **Genitourinary** | **Current** | **Past** |
| Bladder infections | | |
| Vaginal infections | | |
| Frequent urinartion | | |
| Leaking urine | | |
| Blood in urine | | |
| **Blood** | **Current** | **Past** |
| Clotting disorder | | |
| Easy bruising | | |
| Sickle cell anemia | | |
| History blood transfusion | | |
| **Cardiovascular** | **Current** | **Past** |
| Palpitations | | |
| Heart attack | | |

| General | Current | Past |
| --- | --- | --- |
| Stroke | | |
| High blood pressure | | |

**Surgical History**
Have you had any surgeries? Y N

| Year | Surgery |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

**Family Medical History**
Have any of your family members had difficulty conceiving? Y N

Are you aware of any of the following conditions in your family? Answer maybe if you aren't sure, but it's a possibility. Please also indicate the degree of relative if known (mother, aunt, cousin, paternal grandfather etc)

| Condition | Yes | Maybe |
| --- | --- | --- |
| Birth defects | | |
| Blood clots before age 50 | | |
| Bloom syndrome | | |
| Breast cancer before age 50 | | |
| Canavan Disease | | |
| Colon cancer before age 50 | | |
| Cystic fibrosis | | |
| Deafness/blindness | | |
| Diabetes before age 50 | | |
| Down syndrome | | |
| Dwarfism | | |
| Endometriosis | | |

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| Condition | Yes | Maybe |
|---|---|---|
| Familial Dysautonia | | |
| Fanconi anemia | | |
| Galactosemia | | |
| Heart defect from birth | | |
| Heart disease before age 50 | | |
| Hemochromatosis | | |
| Hemophilia | | |
| High blood pressure before age 50 | | |
| Infertility (any cause) | | |
| Marfan syndrome | | |
| Menopause before age 40 | | |
| Muscular dystrophy | | |
| Neural tube defects | | |
| Niemann-Pick disease | | |
| Ovarian cancer before age 50 | | |
| Polycistic kidney disease | | |
| Sickle cell anemia | | |
| Tay-Sachs disease | | |
| Thalassemia | | |
| Thyroid conditions | | |
| Other (please specifiy | | |

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In your opinion, why are you having trouble conceiving?

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

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# Consent

Naturopathic Medicine is the treatment and prevention of diseases using natural therapies and treating the person as a whole, and as an individual. Naturopathic doctors use many modalities and therapies that are used to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, and may do a screening physical examination, including a breast exam and may suggest labs or copies of lab work completed by your medical doctor.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication, supplements or over the counter drugs. Inform your Naturopathic doctor of any changes to these. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

As a patient it is your right to receive information about your diagnosis as well as treatment, including treatment alternatives, costs, benefits, risks, adverse effects, and consequences of not treating. As with any form of medical treatment, there are some risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from injections or acupuncture

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee of $0.10 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all possible risks and complications. With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please Print) ________________________________________

Signature of Patient or Parent/Guardian: _______________________________ Date: _____________

Naturopathic Doctor: ________________________

**Please ensure to give at least 2 hours cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on within two hours or missed appointments, 100% of the cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Naturopathic doctor. Please be aware that phone calls and emails outside of appointments are for clarification purposes only, beyond this is subject to additional consultation fees.**

I, __________________________ (Name), understand and accept the above policies and associated fees.

Signature: _______________________________________ Date:___________________