Total Wellness Centre
10 Roden Place
Toronto, On M5R 1P5
www.totalwellnesscentre.ca
416 532 9094

Patient Fertility Questionnaire

This questionnaire is strictly confidential and will be shared only with your practitioners.

Are you currently undergoing medical fertility treatment? Yes No

If Yes: ______ 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
______ Naturopath
______ Herbalist
______ Homeopath
______ Nutritionist
______ Other:____

Have you had acupuncture before? Yes No

<u>Life Style</u>: Please Circle all that apply

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

Chocolate/Sweets/Deserts – 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 number of hours/night ______

Quality of sleep: poor / fair / good / excellent

Cigarettes/cigars – Number per week ______

Recreational drugs – Number of times per week _____

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

Are you a vegetarian? _______

If yes: ___ Lacto ___ Fish is allowed ___ Vegan

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

Is your appetite:
___ Normal ___ Tendency to overeat ___ Tendency to under eat ___ Need to eat frequently

Menstruation:

Age at first menses (first period):____________________

How often are your periods?____________________

Are your periods irregular?____________________

Number of days your periods last?____________________

Date of the first day of your last period:____________________

Approximate date of the period before that:____________________

Is your period flow thin and clear or thick and sticky?____________________

What color is your period?____________________

Do you have lower abdominal pain during your periods?____________________

Before or after your periods, do you feel any discomfort?____________________

Do your breasts feel swollen during your periods?____________________

What is the amount of bleeding; light-heavy?____________________

Do you have blood clots?____________________

Leucorrhea:

How much leucorrhea (discharge) do you have, if any?________________

Is your leucorrhea thin or thick?________________

What color is your leucorrhea?________________

Does your leucorrhea have odor?________________

Obstetrical History:

Have you ever been pregnant? Yes No

If you have been pregnant:

How many times have you been pregnant?________________

How many full term babies?________________

Ages of children:________________

Miscarriages & dates:________________

Induced (therapeutic) abortions & date:________________

Contraceptive History:

Have you ever used any birth control? Yes No

If "Yes", which methods and for how long (e.g. birth control pill, IUD, condoms, diaphragm, etc):________________

Reproductive History:

How long have you been trying to get pregnant?________________

Approximately how many times do you have intercourse?

Twice per week or more ( )

Less than twice per week ( )

Do you have bleeding after intercourse? Yes No

When was your last Pap smear?________________

Was it normal or abnormal?________________

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Partner

Does your husband or partner have any significant health problems including prostate infection, bladder infections, a sexually transmitted disease, injury to the scrotum or mumps infection as a child?______________________________

Has your husband or partner had any operations?______________________________

Does your husband or partner have any allergies to medications?________________________

Sperm count Yes No
Were the sperm counts normal? Yes No
If not normal, what was the spermatozoa count?____________________________
Were you given any other information about the spermatozoa count? Yes No

Please specify which of the following tests have been performed:

You

Have you had ultrasound test?______________________________________

What was the result of this ultrasound?__________________________________

Have you had a Laparoscopy Yes No
If yes, when was the laparoscopy done?________________________________

What were the findings of the laparoscopy, if any?____________________________

Have you had an X-Ray of fallopian tubes? ________________________________

Are they open or blocked?____

When was the X-Ray done?____

Have you had the special ultrasound test of the Fallopian tubes? (This is called a sonohysterogram and is not a regular pelvic ultra sound.) Yes No
If yes, were the fallopian tubes open or blocked?____________________________

And when was this special ultrasound done?______________________________

Patient Fertility Questionnaire

Have you had the following?

Blood tests Yes No
Temperature Charts Yes No
Endometrial Biopsy Yes No
Post-coital mucus testing Yes No
(checking sperm activity in vagina after intercourse)

What were you told was the cause of the infertility?____________________________________
____

Have you had any treatments for your problem?_______________________________________
____

Please answer the following Yes or No.

1. Do you bleed between periods? Yes No
2. Does it itch or irritate? Yes No
3. Do you urinate too often? Yes No
4. Does it burn to urinate? Yes No
5. Do you get up at night to pass urine? Yes No
6. Do you lose urine when you cough or sneeze? Yes No

7. Does it hurt to have intercourse? Yes No
8. Have you had a blood transfusion? Yes No
9. Have you been treated for a nervous condition? Yes No
   If yes, please outline treatment, e.g. medications used________________________
   ____
10. Do your breasts leak fluid or milk? Yes No
11. Do you have acne problems? Yes No
12. Are you constipated often? Yes No
13. Do you pass blood in your stool? Yes No
14. Is your stool black in color? Yes No
15. Have you gained or lost an excessive amount of weight recently? Yes No
16. If you gained weight or lost weight how much did you gain or lost? And over what length of time?____
   ____
17. Is your appetite poor? Yes No
18. Any abdominal pain? Yes No
19. Do you smoke? Yes No
   If yes how many cigarettes per day?______________________________
20. Do you have headaches? Yes No
   If yes are they migraine headache________________________________
21. Have you a thyroid problem? Yes No
22. Have you had chest problems? Yes No

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23. Do you have high blood pressure? Yes No
24. Do you have heart problems? Yes No
25. Do you have varicose veins? Yes No

26. Have you had liver disease? Yes No
27. Have you had any kidney problems? Yes No
28. Do you drink alcohol? Yes No
    If yes how much per day/week/month?______________________________
29. Do you use drugs e.g. marijuana or other mood-altering drugs? Yes No
    If yes specify drug & frequency of use______________________________
30. Do you have excess hair growth on your body? Yes No

Have you had any of the following?

- ☐ Anaemia
- ☐ Arthritis
- ☐ Allergies (not including drug allergies)
- ☐ Bladder infections
- ☐ Diabetes
- ☐ Epilepsy (convulsions)
- ☐ Haemorrhoids
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Venereal disease

Family History:

Check off if any of these have occurred in your immediate family:

- ☐Birth defects
- ☐Kidney disease
- ☐High blood pressure
- ☐TB
- ☐Twins, triplets
- ☐Heart disease
- ☐Diabetes

Are there other diseases that run in your family?____
____