



Review of Systems (For Fertility Patients)

Name:

Date of birth:

Today's Date:

YOUR HEALTHCARE TEAM

Please list all healthcare practitioners who help treat you:

Name	Type of practitioner (eg. family doctor, counsellor, acupuncturist, RMT)	Phone and fax number
		Phone: Fax
		Phone: Fax:
		Phone: Fax:

MEDICATION YOU ARE CURRENTLY TAKING

Name/ brand/ type	Dose	For what condition	Since when

PAST MEDICATION

Name/ brand/ type	Dose	For what condition	For how long?

NATURAL HEALTH PRODUCTS YOU ARE CURRENTLY TAKING

Product/ brand	Dose	Reason	Since when

MEDICAL HISTORY		
Have you ever been hospitalized/ had surgery?		
Date:	Reason	Problems experienced since

For each item, please circle symptoms that you are experiencing or have experienced

SKIN, HAIR, NAILS			
Redness/ rashes/ eczema/ psoriasis/ hives/ itching		Acne/ boils/ infection/ bumps/ lumps	
Excess dryness/ excess sweating/ sensitive		Moles/ skin ulcers/ discoloration/ cancer	
Hair loss/ hair changes		Nail changes (shape, strength, thickness)	
Have you ever had a complete skin exam?		Date:	
HEAD			
Headache/ Dizziness		Head injury	Problems with jaw joint? (TMJ)
Have you ever had an MRI, CT Scan etc?		Date:	Result:
EYES			
Impaired vision/ double vision/ blurring/ floaters		Glasses/ contact lenses	
Eye pain/ itching/ discharge/ light sensitive		Excess tearing/ dryness/ redness	
Glaucoma/ cataracts			
When did you last visit your eye doctor?		Do you use eye drops, artificial tears or other eye products?	
EARS			
Earache/ Infection		Excess ear wax / Discharge	
Ringing/ Impaired hearing		Ruptured ear drum/ Ear tubes	
NOSE AND SINUSES			
Frequent colds/ stuffiness		Sinus problems/ Nose bleeds	Allergies/ hay fever
MOUTH, THROAT AND NECK			
Frequent sore throat/ hoarseness/ sore or dry tongue/ mouth		Gum problems/ bleeding	
Lumps/ swollen glands in neck		Thyroid problems/ goiter	Pain/ stiffness in neck
How often do you brush and floss?		How many dental cavities?	

	What type of filling?
When was your last visit to the dentist?	
RESPIRATORY	
Cough/ wheezing / sputum/ mucous/ blood Pain/ difficulty breathing/ Shortness of breath/ apnea	
Asthma/ Bronchitis/ Pneumonia/ Emphysema/ Pleurisy (inflammation of lungs)/ Tuberculosis	
Do you / have you smoke(d)?	How long? How many?
Tuberculin test Date: Test result:	Date of last chest x-ray
CARDIOVASCULAR	
High blood cholesterol/ Heart disease/ High blood pressure Angina/ chest pain	
Murmur/ irregular heart beat/ palpitations/ fluttering	
Swelling in ankles Rheumatic fever/ Cyanosis (blueness)	
Past ECG/ Stress test/ other imaging Date:	Result:
BREASTS	
Lumps/ skin puckering/ Pain or tenderness/ change in appearance Nipple discharge/ changes	
Implants/ reduction/ surgery	
Have you ever breast fed?	Do you do self exams?
Any problems breast feeding?	Mammograms/ imaging?
Is there is history of breast cancer in your family?	
GASTROINTESTINAL	
Heartburn/ acid reflux/ nausea/ vomiting/ blood Excess gas/ Indigestion/ bloating/ abdominal pain	
Trouble swallowing/ Changes in appetite/ thirst Offensive breath/ bad taste in mouth	
Ulcer/ Hernia/.Polyps Diarrhea/ constipation/Rectal bleeding/ hemorrhoids	
Blood/ mucous/ undigested food in stool Black tarry stool	
Gall bladder disease/ stones/ removal Liver disease/ hepatitis	
How often are your bowel movements? Is this a change?	
Food allergies/ sensitivities? Please list offending foods:	
How is your appetite?	
<ul style="list-style-type: none"> a) I'm hungry all the time and can't seem to satisfy my hunger (regular meals aren't enough) b) It seems normal to me (eat regular meals) c) I'm not often hungry and I sometimes have to force myself to eat (can easily skip meals) 	

How is your thirst? a) I've noticed an increased thirst that I can't satisfy (drink a lot of fluids throughout the day) b) It seems normal to me (drink fluids throughout the day) c) I'm not usually thirsty (I forget to drink fluids)	
What food restrictions do you have? Do you follow any special diet?	
Do you have any food cravings? Please list the foods that you crave most: _____ What affects your food cravings? _____	
How much water do you drink? (do not include caffeinated drinks or alcohol) Do you drink tea, coffee, or pop? _____ How much? _____ Do you drink alcohol? _____ What kind? _____ How much? _____	
Please circle the following products that you consume on a regular basis (several times per week) Salt Butter Margarine Sugar Artificial sweetener Mayonnaise Soy sauce Spice mixes Jarred or canned sauces Frozen or instant foods Snacks (chips, cookies, candy, candy bars etc) How many meals per week do you eat out? _____ Meals/ week _____	
Have you had any gastrointestinal surgeries/ tests?	Do you take antacids/ special digestive aids?
Is there a history of colorectal cancer in you family?	
URINARY	
Kidney problems (stones, infections)	Urinary tract or bladder infections
MUSCULOSKELETAL	
Joint pain/ stiffness/ swelling/ Arthritis/ Back pain	Muscle weakness/ spasms/ cramps/ sciatica
Bone fractures/ nerve pain or injury	Have you ever had a bone density test?
History of joint or bone injury/ accidents	
PERIPHERAL VASCULAR	
Cold hands/ feet	Deep leg pain/ leg cramps/ Vein pain (thrombophlebitis)
Varicose veins	Extremity numbness/ swelling/ pain/ ulcers
NEUROLOGIC	
Fainting / loss of balance/ loss of memory	Numbness or tingling/ loss of control/ Paralysis
Seizures/ convulsions/ involuntary movement	Speech problems/ slurring

ENDOCRINE			
Very sensitive to heat or cold		Hypoglycemia (low blood sugar)/ Diabetes	
Thyroid problems		Hormone/ steroid therapy	
Excessive thirst/ hunger		Excessive urination/ sweating	
BLOOD/ LYMPHATIC			
Anemia	Easy bleeding/ bruising	Lymph node swelling	
Hemophilia/ clotting problems/ Blood transfusions		What is your blood type?	
ALLERGIES			
Any reactions to vaccines?		Drug sensitivities	
Please list all allergies			
MENTAL EMOTIONAL			
Mood swings/ Sleeping difficulties/ insomnia		Depression	
Anxiety Excess stress		Phobia	
Have you experienced past trauma/ significant grief?			
Are you still affected by it today?			
Substance abuse?		Have you been treated for substance abuse?	
Thoughts of suicides/ attempts?			
Have you ever sought help or used medication to deal with personal problems?			
SLEEP			
How many hours do you usually sleep?		How many hours of sleep do you <i>need</i> ?	
If you have trouble sleeping, please circle all that apply			
a) I have problems falling asleep b) I have problems staying asleep. If so, what time(s) do you usually wake up? _____ c) I take medication or other substances to help me sleep			
Do you awake well rested?		Do you take naps during the day?	
Do you fall asleep during the day?		Do you talk/ walk in your sleep?	
Grind teeth while sleeping		Have vivid dreams	
Sleep apnea		Shift work	
ENERGY			
How is your energy? (please choose one)			
a) I have plenty of energy for work and for all my daily activities b) I have enough energy during work, but feel tired for the rest of the day c) I don't have enough energy for work or any other activities			

What affects your energy level?		
EXERCISE		
How would you describe your daily activity level?		
<ul style="list-style-type: none"> a) very active b) moderately active c) sedentary 		
Do you exercise regularly?		
How frequently?	What kind?	For how long?

FAMILY MEDICAL HISTORY			
Has anyone in your family (siblings, parents, grandparents) had the following conditions?		Which member was affected by this condition	Age
Heart disease			
High blood pressure			
Diabetes/ blood sugar problems			
Asthma or other respiratory (lung) problems			
Allergies			
Cancer (breast, colon, lung, liver, skin, prostate etc)			
Psychiatric (depression, anxiety, addiction etc)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, testosterone, adrenal (cortisol) etc)			
Congenital (birth)/ developmental problem or genetic			
Neurologic problems (eg. MS, parkinson's, Alzheimer's)			
Arthritis			
Digestive (Celiac's disease, Crohn's, Ulcerative colitis, Irritable Bowel Syndrome, Diverticulitis, Lactose intolerance, Gall stones etc)			
Other			

In case of emergency call:	
Name:	Relationship:
Phone:	
Do you have any life threatening allergies (ie. anaphylaxis, medication)?	

Female Fertility Questionnaire and Worksheet

How long have you been trying to get pregnant? _____

How often do you have intercourse without birth control?

twice per week or more

less than once per week

Do you experience pain, discomfort or bleeding after intercourse? _____

How is your libido? (circle) low average OK high

What medical fertility treatment are you currently undergoing?

none

medicated IUI

cycle monitoring + time intercourse

IVF

natural IUI

donor egg IVF

other: _____

Are you receiving other alternative/ natural treatment (s) related to your fertility?

no

yes (please circle) Massage therapy, acupuncture, chiropractic, naturopath, herbalist, homeopath, nutritionist,
other: _____

Briefly explain the treatment (eg. frequency, supplements, etc)

Menstruation:

Age of first period (menses): _____

Length of cycle (number of days from first day of period to last day before period starts): _____ days

Are your periods irregular? N Y

Number of days of period bleeding: _____

Bleeding in between periods? N Y

Date of the first day of your last period: _____

Approximate date of the period before that: _____

Describe the blood/ flow: (circle all that apply) thick/ thin, bright red/ dark, clots, light/ heavy

other: _____

Day of ovulation: _____

Do you notice any ovulation signs or symptoms? _____

Do you experience any discomfort (check all that apply)

___ before the period starts. Where? (eg. breast tender, lower abdomen, low back, headache, bloating etc)

How many days before period? _____

___ during the period. Where? _____

How many days during the period? _____

Do you experience mood changes, energy changes and/ or craving before or during your periods?

Leucorrhea (vaginal fluid/ discharge)

How much leucorrhea do you have? _____

Describe your leucorrhea (circle all that apply): thick/ thin sticky/ watery dry corrosive white/ yellow/ green/ grey other: _____

Odour? (circle) none yeasty fishy foul other: _____

Any vaginal itching or redness? N Y

Obstetrical History:

Have you ever been pregnant? (check all that apply)

___no

___yes With your current partner? N Y

How many times? _____

How many full term births? _____

Ages of children: _____

Miscarriage(s) and date(s): _____

Induced/ therapeutic abortion(s) and date(s): _____

Contraceptive history:

What forms of contraception have you used? For each that apply, please indicate years used (eg Birth control pill 2000-2005)

___ barrier only (condoms, diaphragm, cervical cup, sponge, with or without spermicide etc)

___Birth control pill

___IUD

___Implant, injection or patch (eg. Norplant, Depoprovera, Ortho Evra)

___vaginal ring (eg. Nuva ring)

___ other: _____

Reproductive History:

Are you tracking when you ovulate?

no

yes. What method(s) are you using to track your ovulation (circle all that apply):

Basal body temperature cervical mucus urine ovulation kit saliva ovulation kit counting days

other: _____

When was your last PAP test/ gynecological exam? _____ Any history of abnormal results?

Any history of cervical cancer/ dysplasia or treatment for dysplasia? _____

Any history of sexually transmitted infection? If yes, please indicate which one(s)

Any history of:

frequent candida/ yeast infections

frequent urinary tract infections (pain, burning, urgency)

bacterial vaginosis

interstitial cystitis

pelvic inflammatory disease

Have you ever had any lower abdominal/ pelvic surgery? _____ If yes, please provide details

Reproductive system assessments:

Please indicate if you have had any of the following tests/ imaging/ assessments (include dates and results beside the items that apply to you)

blood tests specific for fertility (hormones, thyroid) _____

Ovarian reserve test (AMH) _____

pelvic and/ or ovarian ultrasound _____

laparoscopy _____

x-ray or ultrasound of fallopian tubes _____

endometrial biopsy _____

post coital mucus test _____

other: _____

Have you been given any of the following diagnosis related to your fertility or reproductive system (check all that apply)

Endometriosis

Polycystic Ovarian Syndrome (PCOS)

Hypo/Hyperthyroid

Cystic fibrosis

Elevated FSH and/or prolactin

Blood disorder

Fibroids

"Unexplained infertility"

Diabetes

Partner:

Has your partner had a full sperm and semen analysis?

no

Yes. Date of test_____ Results? _____

Does your partner have any sexual function or reproductive health issues? _____

Does your partner have any general health issues? _____

Mental Emotional Factors:

Thinking about your fertility issues, struggles and challenges, write a paragraph expressing whatever feelings, images, moods, thoughts you have about having a baby, about your body, about your relationship with your partner and with friends and family, and about your experiences with medical staff and procedures and other practitioners and therapists at this point. You can write as much or as little as you want. If you need more space, you can attach extra pages.

Would you be interested in or open to integrating hypnotherapy in your treatment plan?

Informed consent to Naturopathic Therapeutic Procedures

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (ND) assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. A number of modalities are used by the ND and your treatment may include the following:

Nutrition: This may include individualized diets and nutritional supplements for treatment or prevention.

Asian medicine: This may include acupuncture, cupping, diet therapy, herbs and other hands on therapies to balance body functions. Acupuncture treatments are performed using sterilized single-use needles.

Lifestyle counseling: Lifestyle habits contribute to health. The ND will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment.

Botanical Medicine: The use of plant based medicines and compounds to treat conditions.

Homeopathy: Remedies made from minute doses of natural substances may be recommended to increase the body's ability to heal itself and attain balance.

Physical medicine: Refers to the use of hands-on techniques to bring about healing in the body.

Diagnostic tests: When appropriate, the ND may recommend tests. Tests may be carried out in-house or some cases you may be referred to your medical doctor or other professional for additional tests.

Hypnotherapy: Dr. Ling is a certified hypnotherapist. Hypnosis techniques may be integrated with your naturopathic treatments. Patients learn self-hypnosis techniques to enhance relaxation, reduce stress, help change habits and even improve self-confidence. To be a certified hypnotherapist, one must receive training that is approved by the National Guild of Hypnotists.

Even the gentlest therapies may be contraindicated in conditions such as pregnancy and lactation, in very young children, those with compromised immune functioning or those with multiple medications. Some therapies must be used with caution in certain conditions such as diabetes, heart, liver or kidney disease. Therefore, it is very important that you inform the ND immediately of any condition that you are suffering from and if you are on any medication. If you are pregnant or you are breast feeding, advise the ND immediately.

Any medical treatment carries possible health risks. In naturopathic medicine these may include, but are not limited to: Aggravation of a pre-existing condition; Adverse reactions to supplements and herbs; Pain, bruising or injury from acupuncture, injections or other administered tests

I, _____, do hereby acknowledge and I have been informed of and understand the recommended naturopathic therapeutic procedures as listed above and have discussed with satisfaction this and any related information with the ND named below. I understand that the ND will answer my questions, to the best of her ability, regarding all therapeutic procedures with respect to financial costs, expected benefits, potential risks and side effects; the likely consequences of not having/ following the procedure(s)/ plan, and what alternative course(s) of action are available to me.

I further understand that Total Wellness Centre will keep a record of all health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or required by law in accordance to the clinic's Privacy Policy.

As a result, I do hereby voluntarily consent to naturopathic treatments for my conditions from time to time. I understand that I may withdraw my consent at any time and in doing so I understand that I will not continue to receive naturopathic treatment.

Patient/ lawful representative signature: _____ Date: _____

Naturopathic Doctor (print & signature): _____ Date: _____

Witness (print & signature)* : _____ Date : _____ *Advised but not necessary