

Fertility Treatment Patient Intake Form

Date: _____

Name: _____	Age: _____	Date of Birth: _____	Postal Code: _____
Address: _____		City: _____	Postal Code: _____
Home Phone: (____) _____		Work Phone: (____) _____	
Emergency Contact : _____		Phone: _____	
Occupation: _____			

Referral Source (please circle any/all which apply)

- | | |
|--------------|-------------------------------------|
| Yellow Pages | Other media (TV, Newspaper article) |
| Website | Health Care Practitioner _____ |
| Street Sign | Friend/Family _____ |

Please list any health conditions you have

1. _____
- 2.. _____
- 3.. _____
- 4.. _____
- 5.. _____

What medications, treatments or supplements are you currently taking?

- | | | |
|-------|--------------|------------------------------|
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |

1) Are you planning to do(circle whichever apply) **IUI** or **IVF** or **FET** along with the acupuncture fertility treatments at our clinic? Will you do **ICSE**?

If so, then which medications/injections have you been prescribed for these procedures?

2) For how long have you been having fertility issues? _____

3) How many IUI or IVF cycles have you done to date? _____

For Females(circle yes or no, or fill in blank):

Number of pregnancies _____ Number of live births _____

Length of menstrual cycle (ie: 28 days): _____

Length of period (ie 5-6 days) _____

Menstrual flow(circle one) very light light medium heavy very heavy clotting? Y N

Are you aware of your time of ovulation? _____

What method do you use to measure ovulation if any? _____

For Women: Mark off which apply to you: use an N for now, or a P for past

Fibroids	Ovarian cysts	Polycystic Ovary	Irregular Cycle
Blocked tubes	Pelvic Inflam Ds	Genital Herpes	Gyn/Breast Cancer
Frequent yeast or urinary infections	Endometriosis	Painful Menses	Hot Flashes
Uterine Prolapse	Anatomical Issue with Uterus	Retroversion/flexion of uterus	Thyroid Disease

For Men/Male Partner of Female Patient(even if not coming in to clinic)

Do you have low sperm count? _____ Do you have lowered sperm motility? _____

Do you have any problems with poorly formed sperm? _____

Age(if not coming in as a patient): _____

For Men: Place a N in the box for Now, and a P in the box for Past.

Prostatitis	Cancer	Thyroid Disease	Reversal of vasectomy
Kidney Disease	Trauma to testicle	Spermatocele/Hydrocele/Varicocele	Epidydmits

The rest of the questionnaire is for both Men and Women

How much of the following are you using?

Tobacco:	Alcohol:
Coffee/Non herbal Tea:	Recreational Drugs:

Which of the following conditions have you had? Place a N in the box for Now, and a P in the box for Past.

Abscesses	Diabetes	Herpes Genetalia	Parasites	Other STDs	Venereal Warts
Alcoholism	Emphysema	High Cholesterol	Pelvic Inflammatory D.	Skin Disease	Warts
Allergies	Epilepsy	Influenza	Peritonitis	Strep Throat	Whooping Cough
Anxiety	Gall Stones	Kidney Disease	Pleurisy	Sinusitis	Worms
Arthritis	Goitre/Thyroid	Leukemia	Pneumonia	Sunstroke	Yellow Fever
Asthma	Gonorrhea	Malaria	Prostatitis	Stroke	Other(list here)
Cancer	Gout	Migraines	Rheumatic Fever	Syphilis	
Chicken Pox	Hay Fever	Miscarriage	Rubella	Tonsillitis	
Cold Sores	Heart Disease	Mononucleosis	Scarlet Fever	Tuberculosis	
Depression	Hepatitis	Mumps	Sexual Abuse	Typhoid Fever	

ANY OTHER MAJOR CONDITIONS? _____

Are there any of the preceding conditions after which you have never been totally well again or which have been more severe than usual? Which ones? _____

Please indicate below, which of the following ailments have affected your relatives?

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhoea	Heart Disease	Pneumonia	Tuberculosis

Do you have any dietary restrictions? (vegetarian/vegan, religious, food allergies/intolerances etc.)
