

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 share 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

Life Style: 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: _____

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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 periods: _____

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? _____

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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? _____

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Have you had the following?

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

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?

- | | |
|---|---|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Haemorrhoids |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Allergies (not including drug allergies) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Epilepsy (convulsions) | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Venereal disease |

Family History:

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

- | | |
|--|--|
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Twins, triplets |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> TB | |

Are there other diseases that run in your family? _____
