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, cousellor, 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? Any problems breast feeding?		Do you do self exams? 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? 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 *need*?

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? 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, Alzeimer'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 spermacide 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

__Elevated FSH and/or prolactin

__ Fibroids

__Diabetes

__Cystic fibrosis

__Blood disorder

__"Unexplained infertilty"

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 does 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 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 administrated 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