

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?	
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?		
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)?	

Male Fertility Questionnaire and Worksheet

How long have you and your partner been trying to conceive? _____

What medical fertility treatment are you and your partner currently undergoing?

none medicated IUI

cycle monitoring + time intercourse IVF

natural IUI donor egg IV

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)

How would you describe your libido/ sexual energy? (circle) low average OK high

How often do you ejaculate (either through masturbation or sexual activity/ intercourse)?

_____ times per day or _____ times per week

How would you describe your sexual functioning? below satisfactory satisfactory

Reproductive Medical History

When was the date of your last full physical exam and blood test? _____

Did your physical exam include a prostate, hernia ("turn and cough") and testicular exam?

Have you experienced or been diagnosed with the following: (if yes, please include dates)

N Y sexually transmitted infection

N Y undescended or abscent testicle

N Y testicular varicocele or hydrocele ("lump" in the testicle)

N Y small or soft testes

- N Y erectile or ejaculation difficulties
- N Y enlarged or irregular prostate
- N Y abnormal penile discharge
- N Y pain, burning, urgency, dribbling or other unusual symptoms when urinating
- N Y high blood pressure
- N Y high cholesterol or blood triglycerides
- N Y diabetes or abnormal blood sugar
- N Y steroid, growth hormone or testosterone use
- N Y use recreational drugs
- N Y testicular or prostate cancer
- N Y urologic surgery (such as vasectomy)
- N Y mumps or malaria
- N Y genetic condition (such as Klinefelter's Syndrome)

Medical Tests and Assessments:

Have you had your hormone levels tested? (please circle all that apply)

Testosterone Estrogen Progesterone Thyroid DHEA cortisol

Have you had a sperm and semen analysis?

___ no (please discuss and make arrangements with your MD)

___yes. Date of analysis: _____

Sperm count _____ million/ mL

Motility _____%

Morphology _____%

Semen volume _____mL

How many days of abstinence (from ejaculating) prior to collecting the test sample_____

Semen fructose _____mg/ mL

DNA sperm fragmentation _____%

If you have impregnated a female the past, please give details for each known pregnancy (carried to full term, miscarriage or therapeutic abortion; your age at the time; any complications in the pregnancy)

Partner:

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