

## Women's Fertility Intake

Date: \_\_\_\_\_

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Name: _____	Occupation: _____
Date of Birth: _____	Employer: _____
Home Address: _____ _____	Work Tel #: _____
Home Tel #: _____	Emergency Contact #: _____
Cell #: _____	Contact Relationship: _____
E-Mail Address: _____	Marital Status: _____

Please list any other medical providers:

Type of Medical Provider	Name	Phone #	Address

### **MENSTRUAL HISTORY:**

Age at which menses began: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

How many days does your menses last for? \_\_\_\_\_

Are your menstrual cycles spaced irregularly?  Yes  No

How many days are there from one period to the next? \_\_\_\_\_

Are your periods painful:  Yes  No; If yes how many days does the pain last? \_\_\_\_\_

How heavy is the bleeding?  Light  Normal  Heavy

What color is the blood?  Light red  Bright Red  Dark Red  Purple  Brown  Black

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Is there clotting?  Yes  No

Do you bleed or clot between periods?  Yes  No

Have your cycles changed since they began?  Yes  No

If yes, describe how? \_\_\_\_\_

Do you ovulate on your own?  Yes  No

On what day of your cycle do you ovulate? \_\_\_\_\_

Do your breasts become tender during your menses?  Yes  No

Do your breasts become tender pre-menstrually?  Yes  No

Do you get premenstrual low back pain?  Yes  No

Do your bowel movements become loose at the beginning/during your period?  Yes  No

Do you have premenstrual symptoms?  Yes  No; If YES: describe \_\_\_\_\_

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Does your face break out before or during your period?  Yes - before  Yes -during  No

Do you have nipple discharge?  Yes  No

Do you chart your cycles?  Yes  No

Do you chart your Basal Body Temperature?  Yes  No

## **MEDICAL HISTORY:**

How many pregnancies have you had? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Have you had any abortions?  Yes  No

▪ If YES, when did the abortion take place: \_\_\_\_\_

▪ How many abortions have you had: \_\_\_\_\_

Have you had any miscarriages?  Yes  No

▪ If YES, when was the last miscarriage: \_\_\_\_\_

▪ How many miscarriages have you had: \_\_\_\_\_

Have you had any D&C performed?  Yes  No

Have you ever had an abnormal pap smear?  Yes  No

Have you ever had a cervical biopsy, operation, cauterization or conization?  Yes  No

▪ Please specify: \_\_\_\_\_

Have you ever had an STI (Sexually Transmitted Infections)?  Yes  No

Have you ever been diagnosed with a Chlamydia infection?  Yes  No

Have you ever been diagnosed with a Herpes genitalis?  Yes  No

Do you get yeast infections regularly?  Yes  No

Do you have chronic vaginal discharge?  Yes  No

Have you ever had pelvic inflammatory disease?  Yes  No

Were you treated for it?  Yes  No

How? \_\_\_\_\_

Have you ever been diagnosed with uterine fibroids?  Yes  No

If YES: when were they diagnosed: \_\_\_\_\_

Have you ever been diagnosed with endometriosis?  Yes  No

If YES: when were they diagnosed: \_\_\_\_\_

Have you ever been diagnosed with pelvic adhesions?  Yes  No

Have you ever been diagnosed with pelvic abnormalities?  Yes  No

Have you been diagnosed with a thyroid condition?  Yes  No

If YES: are you on any medications? \_\_\_\_\_

Do you experience fatigue?  Yes  No

Have you ever taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	When/How Long

Are you taking any medications currently?  Yes  No

If YES: specify: \_\_\_\_\_

**PERSONAL HISTORY:**

How long have you been trying to conceive? \_\_\_\_\_

Have you had a diagnosis relating to infertility?  Yes  No

▪ What was the diagnosis? \_\_\_\_\_

Have you had fertility treatments?  Yes  No

If YES: when and where? \_\_\_\_\_

What types? \_\_\_\_\_

Date of last PAP smear: \_\_\_\_\_

Have you taken medication to help you ovulate?  Yes  No

When: \_\_\_\_\_ How long? \_\_\_\_\_

Have your fallopian tubes been evaluated medically?  Yes  No

What were the results? \_\_\_\_\_

Have you had any tubal operations?  Yes  No

Have you had any hormone laboratory tests performed?  Yes  No

▪ What were the results? \_\_\_\_\_

Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

### CONTRACEPTIVE USE HISTORY:

Have you taken oral contraceptives?  Yes  No

▪ When? \_\_\_\_\_ How long? \_\_\_\_\_

▪ Reason for oral contraceptive use: \_\_\_\_\_

Have you ever used an IUD?  Yes  No

▪ When? \_\_\_\_\_ How long? \_\_\_\_\_

▪ Reason for IUD use: \_\_\_\_\_

Have you ever taken Depo-Provera?  Yes  No

▪ When? \_\_\_\_\_ How long? \_\_\_\_\_

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**PARTNER INFORMATION:**

Has your partner had a complete fertility workup?  Yes  No

Has your partner undergone semen analysis?  Yes  No

Is your partner supportive of your wish to conceive?  Yes  No

**OTHER:**

Current Weight: \_\_\_\_\_

Current Height: \_\_\_\_\_

Is there a family history of any congenital birth defects?  Yes  No

How is your sexual desire?  Low  Normal  High

Do you have a stressful occupation?  Yes  No

Do you exercise regularly?  Yes  No How often: \_\_\_\_\_

Have you recently gained or lost weight?  Yes  No; Weight gained/lost \_\_\_\_\_ lbs

Do you have excessive facial hair?  Yes  No

Have you experienced excessive loss of head hair?  Yes  No

Have you noticed discharge from your nipples?  Yes  No

Have you been exposed to any known environmental toxins or hormones?  Yes  No

Are you presently taking any steroids?  Yes  No

Do you smoke?  Yes  No

Do you consume alcohol?  Yes  No

Do you consume caffeine?  Yes  No

Do you use recreational drugs?  Yes  No

Is there anything that you feel is important that has not been covered?

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**HALTON INTEGRATIVE WOMEN'S HEALTH CENTRE**

**INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES**

Name \_\_\_\_\_

Address \_\_\_\_\_

City and Postal Code \_\_\_\_\_

Attending N.D. \_\_\_\_\_

**RECOMMENDED THERAPEUTIC PROCEDURE(S) / PLAN**  
(Including those by referral to another practitioner)

(Filled in at visit)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/ plan and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of and understand the therapeutic procedure(s)/plan with respect to the 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.

As a result I do hereby voluntarily consent/ withhold/ my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary consent at any time.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_ Witness Signature \_\_\_\_\_

Where did you learn about this clinic?

Friend/Family; name: \_\_\_\_\_

Internet:       Google  
                  OAND/CAND  
                  Yellow pages (online)  
                  Canadian Naturopaths website

Other: \_\_\_\_\_

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## **PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

Privacy of your personal information is an important part of our clinic while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Dr. Shahnaz Chowdhury, ND acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our Clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards or our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy.

### **How our clinic collects, uses and discloses patients' personal information**

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements

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- To comply generally with the law
  - To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

**Patient Consent**

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that the Halton Integrative Women's Health Centre can collect, use and disclose my personal information as set out above in the information about the clinic's privacy policies.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_ Witness Signature \_\_\_\_\_



**7 Day Diet Diary**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Lunch							
Dinner							
Snacks							
Fluids							
Comments							

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Check the conditions that you are currently experiencing, or have experienced often in the past.  
If more space is required please use the reverse side of this sheet.

current		previous	current		previous	current		previous
<b>General Symptoms</b>			<b>Cardiovascular</b>			<b>Infections / Illnesses</b>		
Loss of consciousness		<input type="checkbox"/>	High blood pressure		<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Numbness / tingling	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure		<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Plantar warts	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDs	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Artery hardening	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep/insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds / flus	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the ankles	<input type="checkbox"/>	<input type="checkbox"/>	<b>Muscles and Joints</b>		
Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>
<b>Head / Neck</b>			Angina	<input type="checkbox"/>	<input type="checkbox"/>	Backache	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
Type			<b>Genitorurinary</b>			Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			Trouble urinating	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble L / R	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
TMJ concerns	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	Elbow pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hip pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>			Knee pain L / R	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Poor digestion	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin</b>			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Weakness / loss strength	<input type="checkbox"/>	<input type="checkbox"/>
Rashes / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women's Health</b>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>
Boils / Hives	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>
Contagious skin disease	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>			Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Liver concerns	<input type="checkbox"/>	<input type="checkbox"/>	Swollen breasts	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in the breast	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Bladder concerns	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	On birth control	Yes <input type="checkbox"/> No <input type="checkbox"/>	
						# of pregnancies	_____	
						# of children	_____	

**APPOINTMENT CANCELLATION POLICY**

Dear Patient,

Our goal is to provide you with quality medical care in a timely manner. We strive to render excellent care to you, your family, and all of our patients. In order to do so we have had to implement an appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient. Missed appointments can also cause the doctor to wait at the office when they could be providing care to another patient in need.

**Our policy is as follows:**

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment and you will be charged in full for the appointment.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact (office manager's name) at the above address or phone number and she will be glad to clarify any questions you may have.

We thank you for your patronage.

**I have read and understand the Appointment Cancellation Policy and agree to be bound by its terms.**

\_\_\_\_\_ Signature (Parent / Legal Guardian)

\_\_\_\_\_ Printed Name

\_\_\_\_\_ Relationship to Patient

\_\_\_\_\_ Date

**\*\*\* PLEASE RETURN THIS PAGE TO US \*\*\***