

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 shared only with your practitioners.

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? _____

Leucorrhea:

How much leucorrhea (discharge) do you have, if any? _____

Is your leucorrhea thin or thick? _____

What color is your leucorrhea? _____

Does your leucorrhea have odor? _____

Obstetrical History:

Have you ever been pregnant? Yes No

If you have been pregnant:

 How many times have you been pregnant? _____

 How many full term babies? _____

 Ages of children: _____

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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? _____

Have you had the following?

Blood tests Yes No

Temperature Charts Yes No

Endometrial Biopsy Yes No

Post-coital mucus testing Yes No

(checking sperm activity in vagina after intercourse)

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

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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
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 |

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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? _____

Are you currently under the care of another health care practitioner including medical doctors, naturopaths, etc. Yes No

If yes, please list any prescriptions or herbs that you are taking.
