Vibrant Living Wellness

It's Your Life… Live It In Health!

FERTILITY INTAKE FORM

Welcome to VIBRANT LIVING. We are committed to providing you the best medical care possible.
Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.

Name____

Age_________ Date of Birth____________________

Address______________________________________

City State Zip ________________________________

Email____

How did you hear about us? ___________________

☐ Friend ☐ Ad ☐ Website ☐Doctor ☐ Other ________

Date ______________________________

Occupation__________________________

Home phone_________________________

Cell phone___________________________

Work phone__________________________

Your preferred phone # Home Work Cell

May we leave a message? Y N

What is your main reason and/or goal for this appointment?____________________________________
____

How long have you been trying to get pregnant?____

How long have you been doing the Becoming Mama Protocol?____________________________________

Which Fertility Pattern do you think you are?____

Have you been diagnosed with any of the following:

- ☐ PCOS
- ☐ Luteal phase defect
- ☐ Low AMH
- ☐ High FSH
- ☐ Low progesterone
- ☐ Ovarian Cyst
- ☐ Fibroid
- ☐ Migraine headaches
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Epilepsy
- ☐ Bleeding Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Infertility
- ☐ Chronic Fatigue Syndrome
- ☐ Hypertension
- ☐ Osteopenia/Osteoporosis
- ☐ Diabetes
- ☐ Depression
- ☐ Anxiety
- ☐ AIDS/HIV

Please indicate if you have or are taking any of the following:

☐ Pacemaker
☐ Sleeping Aids
☐ Cortisone or other Steroids
☐ Antacids (Tums, etc.)
☐ Clotting Disorder
☐ Blood Thinners (Warfarin, Coumadin, etc)
☐ Diet Pills (diuretics, appetite suppressants, etc.)
☐ Pain Relievers (Tylenol, Aspirin, etc.)
☐ Contagious Disease
☐ Thyroid medication
☐ Laxatives
☐ Tranquilizers/Sedatives

Please list any hospitalizations and/or surgeries/injuries/accidents:

Hospitalization/Surgery/Accident/Injury	Date	Reason / Relation to health concerns

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, supplements, herbs, performance enhancing aids and/or weight loss products:

Name	Dosage	Reason for taking	Date began taking

Approximately how many courses of antibiotics have you taken in the past 10 years?____________________

Allergies (drug, chemical, food, seasonal):____
____

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Genetic Disorder
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Mental Illness
- ☐ Migraine headaches
- ☐ Parkinson's
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Survey of Symptoms: Please check current symptoms (** the ones that occur frequently, and write "past" next to those conditions which you have only had in the past and are no longer present).

Head & Neck:
- □ Dizziness
- □ Floaters
- □ Blurry vision
- □ Neck Stiffness
- □ Enlarged lymph glands
- □ Headaches
- □ Migraines
- □ TMJ

Ears:
- □ Infection
- □ Ringing
- □ Decreased hearing

Nose, Throat, & Mouth:
- □ Nose bleeds
- □ Nasal congestion
- □ Sinus infection
- □ Hay fever/ allergies
- □ Sore throat
- □ Hoarseness
- □ Mouth sores
- □ Dry mouth

Skin:
- □ Hives / Rashes
- □ Eczema
- □ Psoriasis
- □ Acne
- □ Night sweating
- □ Excess sweating
- □ Dry skin
- □ Bruise easily

Respiratory:
- □ Chronic cough
- □ Coughing up blood
- □ Coughing up phlegm
- □ Difficulty breathing
- □ Asthma/Wheezing
- □ Catch cold easily
- □ Emphysema
- □ Pneumonia

Gastrointestinal:
- □ Indigestion
- □ Nausea
- □ Vomit
- □ Bloating
- □ Gas
- □ Heartburn
- □ Distention of abdomen
- □ Stomach pain
- □ Irritable Bowel
- □ Colitis
- □ Crohn's Disease
- □ Celiac Disease
- □ Ulcer
- □ Bad Breath
- □ Diarrhea
- □ Constipation
- □ Dry, hard stools
- □ Soft, sticky stools
- □ Blood in stools/black stools
- □ Hemorrhoids
- □ Poor appetite
- □ Excessive hunger
- □ Excessive thirst
- □ Gall Bladder problems/stones
- □ Recent weight change
- □ Food cravings
- □ Hypoglycemia

Urinary:
- □ Frequent day urination
- □ Frequent night urination
- □ UTI/bladder infection
- □ Weak urine stream/dribbling
- □ Kidney disease
- □ Recent change in bladder habits

Muscle & Joints:
- □ Arthritis
- □ Joint stiffness
- □ Sore muscles
- □ Weak muscles
- □ Back pain
- □ Sciatica
- □ Fibromyalgia

Cardiovascular:
- □ Palpitations
- □ Chest pain or tightness
- □ Rapid heart beat
- □ Irregular heart beat
- □ Heart disease
- □ Poor circulation
- □ Cold hands/feet
- □ Swelling ankles
- □ High blood pressure
- □ Stroke
- □ Anemia

Infection:
- □ HIV/AIDS
- □ TB
- □ Hepatitis
- □ STD
- □ Herpes

Neurological:
- □ Numbness or tingling
- □ Seizures / Convulsions
- □ Tremors
- □ Paralysis

General:
- □ Fatigue
- □ Thirst
- □ Chills/aversion to cold
- □ Insomnia
- □ Depression
- □ Agitation/Anxiety
- □ Irritability
- □ Poor memory
- □ Difficulty concentrating
- □ Jaundice
- □ Gout
- □ Hernia
- □ Diabetes Mellitus
- □ Thyroid disorder
- □ Cancer
- □ Alcoholism
- □ Lowered libido
- □ Other _______________

Reproductive Health:

Pregnancies ________________ # Children _____________ # Miscarriages _____________________

Date of last period _____________ Is your cycle regular? Y N Day of cycle you ovulate ____________

# of days of flow_______________ # of days from start of one period to the next: _____________________

Bleeding: □light □normal □heavy □watery □ clots

Color of blood: □light red □red □dark red □purple □brown □black

□ Spot a few days before your period comes □ Bleeding between periods Is your cycle painful? □ Yes □ No
Nature of pains (indicate which days of your cycle or before your cycle the pain occurs)
Cramping___________ Stabbing__________ Burning___________ Aching__________ Dull___________
Intermittent__________ Consistent________ Down-bearing_________ Better with hot -pad____________

PMS symptoms:
□ Breasts get tender or swollen before period: how many days before?________
□ Bloating before your period □ Fatigue □ Irritability □ Melancholy □ Headaches □ Loose stools
□ Increased appetite □ Decreased appetite □ Insomnia

Other symptoms:
□ Hot flashes □ Night Sweats □ Vaginal Dryness □ Frequent yeast infections □ Frequent UTIs

Please indicate whether you have been diagnosed with any of the following:
□Fibroids □Fibrocystic Breasts □Ovarian Cysts □Endometriosis □PCOS □Other_____________

Is there anything else you would like us to know?____
____
____

Thank you for taking the time to answer these questions, we appreciate your time and effort.
I certify that the information I have provided above is correct and accurate to the best of my knowledge.

_______________________________________ __________________________________ _____________
Patient's (or Patient Representative's) Signature *Patient's Name* *Date*

_______________________________________ __________________________________
Patient Representative's Name *Representative's relationship to patient*