BOSTON FUNCTIONAL NUTRITION

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Women's Health/Fertility Intake Form

Welcome to Boston Functional Nutrition! I am looking forward to working with you. The following questionnaire will help me get started working on your case, so we can get the most out of our initial session. It will take some time to complete, so please print this form, grab a cup of tea and give yourself at least an hour to work through it. When complete, you can email this to Ayla@BostonFunctionalNutrition.com or fax to 888-835-5844. Please note that depending on where you are in your journey to pregnancy, some of these questions may not be applicable. Just answer those that are relevant.

Demographics

Name: ____ Age: ________ Date of birth: ____/____/________

Mailing Address: ____

Phone: (______)______-______ Email: ____

Primary Care Physician Name: ____

Primary Care Physician Address: ____

Primary Care Physician Phone Number: (______)______-______ Fax Number: (______)______-______

Gynecologist? ____

Reproductive Endocrinologist (if applicable)? ____

How long have you been trying to get pregnant? ______________________________________

Menstrual History

Date of last menstrual period? ____/____/______ At what age did you begin your menstruation? _____

Do you currently have a menstrual cycle? ☐ Yes ☐ No

How long is your menstrual cycle (ex. 28 days, 30 days, etc.) _____________________________

Is your menstrual cycle regular? (coming at a predicted time or does it vary?) ☐ Yes ☐ No

Have you ever gone more than 2 months without getting your Period? ☐ Yes ☐ No When? _________

What is the duration of your flow? ☐ <3 days ☐ 3-6 days ☐ >6 days

How is your overall flow? ☐ Light ☐ Moderate ☐ Heavy (heavy is soaking through a super pad or tampon every 2 hours or less)

Do you notice blood clots during menstruation? ☐ None ☐ Few ☐ Moderate

What Color is the Blood? (Pale Red Pink Red Dark Red Purple Brown Black) ____________________

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Is the Blood: ☐ Watery ☐ Clotted ☐ Mucousy ☐ Thick ☐ Stringy ☐ Have an Odor

Do you have menstrual cramps? ☐ None ☐ Moderate ☐ Severe

How long do your cramps last? ☐ Hours ☐ Days

Do you have irregular bleeding outside of your menstruation? ☐ Yes ☐ No

What are the symptoms you experience premenstrually? (Please check all that apply.)

☐ Anxiety ☐ Mood Swings ☐ Nervousness ☐ Fluid Retention ☐ Headaches ☐ Food Cravings

☐ Tender Breasts ☐ Difficulty Sleeping ☐ Other: ______________________________

Fertility History

What symptoms do you experience during ovulation? (Please check all that apply.)

☐ None ☐ Vaginal Discharge ☐ Increased Libido ☐ Pelvic Twinge / Pain

How many total pregnancies? ____________ How many pregnancies carried to term? ____________

How many preterm pregnancies? ________________ How many abortions? ______________

How many miscarriages? __________ How many living children?________ Ages:______________

Have you had the following procedures or tests? If so, what were the results?

☐ Hormone levels: __________________________ How recent? __________________________

☐ Hysterosalpingogram (HSG) ? ____

☐ Hysteroscopy? ____

☐ Cervical Conization (biopsy)? ____

☐ Dilation /Curettage (D&C)? ____

☐ Laparoscopy? ____

☐ Mammography? ____

☐ Pelvic / Abdominal Ultrasounds? ____

☐ Pregnancy Termination? ____

Have you had the following Procedures? (Please check all that apply & indicate when.)

☐ Stimulated cycle w/out IUI _________ ☐ ZIFT _________ ☐ Stimulated IUI _________

☐ IVF _________ ☐ Non- Stimulated IUI _________ ☐ IVF/ Donor _________ ☐ GIFT _________

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Partner's History

Has your partner / husband ever had a semen analysis? Yes/No

What were the results? ☐Not applicable ☐Abnormal ☐Normal

Has your partner / husband ever had any of the following? (Please check all that apply.)

☐Varicocele ☐Prostate Problems ☐Lower Back Pain ☐Chronic Pelvic Pain

☐Frequent Headaches ☐Sedentary Lifestyle

Have infections, esp. urinary tract and kidney, been tested/ruled out for your partner? ☐Yes ☐No

Has your partner had any thyroid testing? ☐Yes ☐No

What were the results? ☐Not applicable ☐Abnormal ☐Normal

How often/much does your partner drink alcohol? ______________________________

What is your partner's stress level like? ______________________________

Sexual Health

Do you have a history of abuse? ☐Yes ☐No

Are you satisfied with your current libido? ☐Yes ☐No

Are you well lubricated during intercourse? ☐Yes ☐No

Do you experience pain during penetration? ☐Yes ☐No

Do you have bleeding following intercourse? ☐Yes ☐No

How often do you get vaginal yeast infections? ______________________________

How often do you get bacterial vaginosis infections? ______________________________

How often do you get urinary tract infections? ______________________________

Digestive Health

Do you have acid reflux/heartburn? ☐Yes ☐No

Please fill in the chart below with information about your bowel movements:

A. Frequency: ☐more than 3x/day ☐1-3x/day ☐4-6x/week ☐2-3x/week ☐1 or fewer/week

B. Consistency: ☐soft and well-formed ☐often float ☐difficult to pass ☐diarrhea

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C. Color: ☐ Medium brown consistency ☐ Very dark or black ☐ Greenish color ☐ Blood is visible

☐ Dark brown consistency ☐ Yellow, light brown ☐ Greasy, shiny appearance

Is there anything else you'd like to tell me about your digestive health? ______________________________

____

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other ______________________

In your home or work environment are you regularly exposed to: (Check all that apply)

☐ Mold ☐ Paints ☐ Electromagnetic radiation ☐ Cleaning chemicals ☐ Herbicides or Pesticides

☐ Airplane travel ☐ Water leaks ☐ Stagnant/stuffy air ☐ Air fresheners or candles

☐ Damp environments ☐ Heavy metals (lead, mercury, etc.)

☐ Harsh chemicals (solvents, glues, gas, acids, etc.) ☐ Renovations ☐ Smokers ☐ Chemicals

☐ Carpets/rugs ☐ Heating food in plastic containers

Have you had significant exposure to any harmful chemicals you can think of? If yes, what chemical, length of exposure, date: ____ ____/____/________

What is your source of drinking water? ____

Do you noticed dark circles under your eyes? ____

Sleep

Do you have trouble sleeping? ☐ Yes ☐ No

Do you wake at night to urinate? ☐ Yes ☐ No

At what times do you wake at night? __________ ____

Do you feel rested when you wake? ☐ Yes ☐ No

Are you using electronic devices/watching TV within 2-3 hours of bedtime? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, please explain: ____

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Stress

Please describe your current stress levels and which areas of your life you attribute it too (i.e. work, family, relationships, money, etc.)

____

____

Are you always cold? ☐ Yes ☐ No

Are you sensitive to temperature changes? ☐ Yes ☐ No

Do you experience "brain-fog"? ☐ Yes ☐ No

Do you forget things often? ☐ Yes ☐ No

Mood

Do you experience anxiety or irritability? ☐ Yes ☐ No

Do you experience depression or low mood? ☐ Yes ☐ No

Do you lose your temper easily at times? ☐ Yes ☐ No

Please describe anything you notice about your mood:

____

____

Current Medications/Supplements

List all of your current medications and supplements. Include: NAME, DOSE, and REASON FOR USE.

____

____

____

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Are you allergic to any medications? ☐ Yes ☐ No

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, please describe: ______________________________

Have you used any of these regularly for long periods of time in the past?

☐ NSAIDs (Advil, Aleve, etc.), Motrin or Aspirin?

☐ Anti-histamine Allergy Medication (Zyrtec, Claritin, Benedryl)?

☐ Over the counter sleep aids (Zquil, Simple Sleep, Tylenol PM)?

☐ Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)?

How many times have you taken antibiotics? ______________________________

Have you ever taken long-term antibiotics? ☐ Yes ☐ No

If yes, please explain: ______________________________

How often have you taken oral steroids (Prenisone, Cortisone, etc.)? ☐ Yes ☐ No

Diet

Do you have any food allergies? ☐ Yes ☐ No

Do you avoid any foods? ☐ Yes ☐ No

If so, please list which foods and why: ______________________________

____

____

What are your favorite foods? ______________________________

____

____

What foods do you dislike? ______________________________

____

____

Do you feel your blood sugar/energy levels change dramatically at times? ☐ Yes ☐ No

Do you regularly get symptoms of low blood sugar (irritable, shaky, light-headed, fatigued)?

☐ Yes ☐ No

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Tell Me Your Story

Hearing your story written out in your words is very helpful for my understanding of your health in the context of your life. We will discuss at your visit, but please give me at least a few sentences (but feel free to use the whole space) about anything you'd like me to know about you, your health, or how you think your background may have impacted your current health. Please include any major life events or crises during childhood, adolescence or in recent years and any "hunches" you have about what's going on with your health.

____

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Whole Body Daily Log

Please complete the following log for 3 days and submit or bring with you to your appointment.

BOSTON FUNCTIONAL NUTRITION

WHOLE BODY | MIND | SPIRIT DAILY LOG

NUTRITION

LIST YOUR MEALS AND SNACKS. INCLUDE TIME EATEN.

TRIBE & COMMUNITY INTERACTION

☐ YES ☐ NO

DESCRITION:

____

____

☐ Shared a meal with others

WHO/WHEN/WHERE:

____

____

☐ Had a conversation with a friend

OTHER/NOTES:

____

____

EMOTIONS

☐ ANGER ☐ GRIEF

☐ CONTENT ☐ HAPPY

☐ DEPRESSED ☐ WORRY

☐ FEAR ☐ OTHER: ________

NOTES:

____

____

LIFE BALANCE

What took the most energy today?

____

____

What gave me the most energy today?

____

____

REST & SLEEP

QUANTITY (HOURS): ___________________

QUALITY: ☐ POOR ☐ FAIR ☐ GOOD

DREAMS: ☐ YES ☐ NO

WAKE TO PEE? ☐ YES ☐ NO

HOW MANY TIMES? ______ WHEN? ______

SPIRITUAL PRACTICES

☐ YES ☐ NO

DESCRITION:

____

____

MOVEMENT

DESCRITION: ____

____