Patient Health History Questionnaire and Supplemental Intake Form

MyCatholicDoctor

Patient NaPro/Fertility Supplemental Intake Form

Patient Name (First Name, Middle Initial, Last Name): _____

Date of Birth (MM/DD/YY): _____ Age: _____

Email Address: _____ Date: _____

Please Provide the following information with a brief elaboration if desired

Date of last menstrual period: _____

How far apart are your periods? _____

Please list your height: _____

Please estimate your weight: _____

Any medical problems you have seen a doctor for: _____

Names and dosages of medications:

_____

Any supplements you are taking:

_____

Any allergies to medications: _____

Any family history of breast, ovarian, uterine/endometrial or colon cancer:

_____

Have you ever had a surgery? _____

If yes, any abdominal surgery or laparoscopy? _____

If yes,what was the month/year and was any endometriosis found/treated? _____

Do you follow a special diet? _____

Do you have a regular exercise routine? _____

Do you struggle with your weight (to loose, gain or maintain? _____

Have you ever achieved a pregnancy before? _____

Are you hoping to conceive at this time? _____

When was your last annual exam (pap/pelvic/breast exam)? _____

Average cycle interval (time from start of one menstrual cycle to the next): _____

Length of menstrual flow: _____

Any brown bleeding or spotting at end of period? _____If yes, how many days? _____

Any spotting or bleeding between cycles? _____Is this only after intercourse? _____

Do you experience fertile mucus which looks like a raw egg white throughout the month? _____

Do you know how to identify your "peak day" or date of ovulation? _____

If yes, on which day of the cycle does this usually occur? _____

Which biomarker do you use to identify ovulation?

○ mucus ○ +LH/OPK ○ temperature ○ sensation in pelvis

Do you use a system of NFP (Natural Family Planning)? _____

If yes, which system? ○ CrMS(Creighton Model) ○ Marquette ○ Billings

○ STM/CCL ○ LFMS(Life Flows MED&SURG) ○ An App

If Trying to conceive, do you engage in intercourse:

○ Every day of the fertile window

○ Every other day

○ Remain open in general to achieving pregnancy

Do you experience premenstrual symptoms such as:

○ Emotional shift ○ sadness ○ anxiety ○ irritability ○ difficulty sleeping ○ bloating or cravings

○ None of the above

If so, for how many days before your period starts?

○ 1-3 ○ >3 ○ >1week

Do you have a history of depression or anxiety? _____

If yes,

○ have you been treated for this in the past?

○ currently receiving treatment?

If currently receiving treatment, who do you follow with?

○ primary care physician ○ psychiatrist ○ counselor/therapist

Do you have difficulty sleeping? _____

If yes,

○ medications ○ sleep ○ remedies ○ relaxation routines ○ None

Do you have any spotting before your period starts?_____

If yes, for how many days?_____

Do you have pain with your periods?_____

If yes, is it ○ mild/"normal" ○ moderate ○ severe

What remedies do you try if any?_____

Do you have pain with intercourse? _____

If yes, is it ○ with deep penetration ○ positional ○ during certain times of cycle

Do you feel your libido or sexual desire is adequate? _____

Is it strong around the fertile time?_____

Do you have any ○ regular diarrhea ○ constipation ○ food sensitivities ○ Irritable Bowel Syndrome

Do you describe your stress level as ○ low ○ medium/"manageable" ○ high

How do you cope with stress in general?

_____

What is your occupation?_____

Any history of Polycystic Ovarian syndrome (PCOS) diagnosis? _____

Do you have a history of cystic acne?_____

If yes, ○ painful ○ moderate ○ severe

Do you notice dark hairs on chin, chest, nipple or abdomen area?_____

If yes, do you have to ○ pluck ○ shave ○ wax ○ laser

Do you have a history of skipping periods by 1-2 moths or longer?_____

If yes, when? _____

If Trying to conceive, please answer the following:

How long have you been trying or open to conceiving? _____

Is your partner overall healthy? _____

What is your partner's occupation? _____

Any occupational hazards for either of you? _____

Any smoking, drinking or drug use for either you or your partner? _____

How many total pregnancies have you achieved? _____

Have you had difficulty conceiving? _____

If yes, have you ever had a workup done by a Physician? _____

Have you ever seen a Reproductive Endocrinologist? _____

Has your partner had a semen analysis? _____

If yes, what month/year? _____

Was it considered normal or abnormal? _____

Any special care by urologist? _____

Have you ever had a test to evaluate whether the fallopian tubes are open? _____

If yes, what month/year? _____

Was it considered normal/open? _____

Have you had a history of miscarriage? _____

Any preterm deliveries? _____

Any history of gestational diabetes or gestational hypertension (high blood pressure) _____

Any history of abnormal pap smears or STD's (sexually transmitted infections)? _____

Anything else you would like to add:

_____

Please email your menstrual charts prior to your visit.

☐ By checking this box, I agree to use electronic records and signatures.

Please type your name to sign below:

Signature Date

☐ I am the parent/guardian of this patient