CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

ROBERT SCHAD NATUROPATHIC CLINIC

Fertility Focus Shift Intake Form - Male

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Name _____ Date _____

Date of birth _____ (MM/DD/YY)

Preferred Gender Pronoun ☐ He ☐ She ☐ Other_____ Sex: ☐Female ☐ Male

Address:_____ Apt/unit #_____

City _____ Province _____ Postal Code_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____ Cell: _____

May we leave messages relating to your visits? Y / N Which Phone Number:_____

Emergency contact: Name: _____

Phone number(s): (_____)_____ or (_____)_____ Relation:_____

Partner's name (if applicable) _____ DOB (MM/DD/YY)_____

How did you hear about our Clinic? Please check one of the following:

- ❑ A patient of the clinic (please provide name) _____
- ❑ My medical doctor/Specialist (please provide name) _____
- ❑ Other Health Care Provider (please provide name):_____
- ❑ Advertising (newspaper, TTC, brochure)
- ❑ Social Media (Facebook, Twitter etc.)
- ❑ CCNM Website
- ❑ CCNM Student, staff or faculty
- ❑ Information Session
- ❑ External Sports Medicine event
- ❑ CCNM E-Newsletter
- ❑ Other: _____

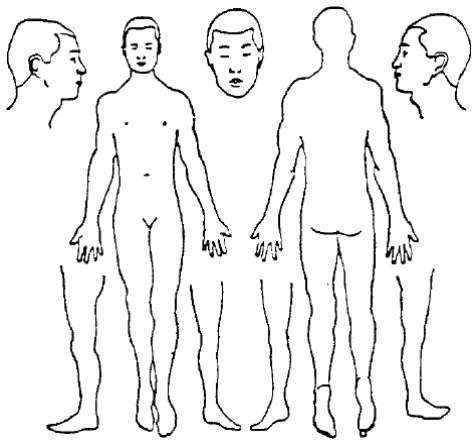
Other health care providers you are seeing:

Name: _____	Name: _____	Name: _____
Specialty: _____	Specialty: _____	Specialty: _____
Phone: (_____) _____	Phone: (_____) _____	Phone: (_____) _____
Date of Last Visit: _____	Date of Last Visit: _____	Date of Last Visit: _____

Have you ever consulted (Please check all that apply):

☐ Naturopathic doctor ☐ Acupuncturist ☐ Nutritionist ☐ Counselor

Health Goals

Please list most important health concerns and goals *in their order of significance*:	Prior diagnosis of this problem? If so, what?	**Indicate Painful or distressed areas:** 
1.		
2.		
3.		
4.		
5.		

Have you ever conceived with your current partner? ☐ Yes ☐ No
Have you ever conceived with another partner? ☐ Yes ☐ No
Have you had a semen analysis? ☐ Yes ☐ No
Have you been evaluated by an urologist? ☐ Yes ☐ No
Have you ever had any of the following sexually transmitted infections?

- ❑ Chlamydia
- ❑ Syphilis
- ❑ Gonorrhea
- ❑ HIV/AIDS
- ❑ Herpes
- ❑ Hepatitis
- ❑ Genital Warts/ HPV
- ❑ Other

Medical history

How would you describe your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations or surgeries; along with approximate dates.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Do you have any allergies (medicines, environmental, etc.)?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please list all <u>current</u> medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Have you ever had any of the following diseases?

☐ Diabetes Mellitus
☐ Cancer
☐ Multiple Sclerosis
☐ Prostatic Infections
☐ Urinary Tract Infections
☐ High Blood Pressure
☐ Sleep Apnea (or loud snoring)
☐Thyroid problems
☐ Anxiety or Depression

Please list <u>past</u> prescription medications/natural health products:

_____

_____

_____

Have you had a history of an undescended testicle? ☐ Yes ☐ No
Do you have scrotal or testicular pain? ☐ Yes ☐ No
Did you have the mumps after puberty? ☐ Yes ☐ No
Have you had a prior injury to your testicles? ☐ Yes ☐ No
Have you had a fever in the last 3 months? ☐ Yes ☐ No
Have you had a vasectomy? ☐ Yes ☐ No
Have you had a vasectomy reversal? ☐ Yes ☐ No
Is ejaculation painful? ☐ Yes ☐ No

What colour is your semen?
☐ White ☐ Yellow ☐ Brown ☐ Red

Have you had surgery for varicocele repair? ☐ Yes ☐ No
Have you had a catheter (tube) put in your penis to the bladder? ☐ Yes ☐ No
Have you had hernia surgery? ☐ Yes ☐ No ___
Have you undergone any bladder or penis surgery as a child? ☐ Yes ☐ No

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers Y N P
Laxatives Y N P Antacids Y N P Diet pills Y N P
Birth control Y N P Type (please circle) Pills / Implants / Injections
Antibiotics Y N P Approximate number of prescriptions: _____
Alcohol—how much/day or week _____
Tobacco—form and amount/day_____
Caffeine—form and amount/day_____
Recreational drugs—what and how often_____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus)
☐ Tetanus booster; when? _____
☐ MMR (measles, mumps, rubella)
☐ Hepatitis A
☐ Hepatitis B
☐ Other: _____
☐ Haemophilus influenza B
☐ "Flu"
☐ Polio
☐ Smallpox
☐ Chicken pox OR had chicken pox previously?

Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Physical , blood tests, etc.)? ☐ Yes ☐ No

Last time you had blood work done_____

Have you travelled recently? Y N If yes, where: _____
Has your partner travelled recently? Y N If yes, where: _____

Diet

Do you have any food allergies or intolerances? Please list.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Personal and Family History

Height: _____ Weight (lbs) _____ BMI _____ (Office Use)

Are you aware of any genetic diseases in your family? (ex cystic fibrosis, Tay-Sachs, Marfans syndrome, thalassemia etc..)

_____
_____

Please list any birth defects that have occurred in your family history: _____
_____

Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes (✓)	Relation Please circle	Dates Resolved		Yes (✓)	Relation Please circle	Dates Resolved
Alcoholism/Drug addiction		Self F M S G C	Past Current	Diabetes		Self M S G C	Past Current
Allergies		Self F M S G C	Past Current	Depression/other Mental Illness		Self F M S G C	Past Current
Anemia		Self F M S G C	Past Current	High Blood pressure		Self F M S G C	Past Current
Arthritis		Self F M S G C	Past Current	Heart Disease		Self F M S G C	Past Current
Asthma		Self F M S G C	Past Current	Heart Attack		Self F M S G C	Past Current
Birth Defects		Self F M S G C	Past Current	Headaches		Self F M S G C	Past Current
Blood Clotting disorders		Self F M S G C	Past Current	Infertility		Self F M S G C	Past Current
Cancer: Breast Colon Ovarian Other: _____		Self F M S G C Self F M S G C Self F M S G C Self F M S G C Self F M S G C	Past Current	Thyroid problems		Self F M S G C	Past Current

☐ I don't know my family medical history

Any other personal or family health concerns you would like us to know? _____
_____

Environment & Social History

Occupation _____
Hobbies _____

Do you exercise regularly? ☐ Yes ☐ No What do you do for exercise, how much, how often?

_____
_____

Are you exposed to significant tobacco smoke (work, home, etc)? ☐ Yes ☐ No
Are you frequently exposed to animals (work, pets, etc.)? ☐ Yes ☐ No
How is your home heated? _____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____

_____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

Are you exposed to prolonged heat in the workplace (or elsewhere)? ☐ Yes ☐ No

How many hours a day do you sit?_____

What type of underwear do you wear?_____

Do you use hot tubs or take hot baths?_____

Emotional Health

On a scale of 1-10 (10 being the highest) estimate the level of stress you feel due to difficulty conceiving?_____

Do you see a counselor? ☐ Yes ☐ No

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

Over the past 2 weeks, how often have you been feeling bothered by the following problems?
(0=not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day)

1. Little interest or pleasure in doing things 0 1 2 3
2. Feeling down, depressed or hopeless 0 1 2 3

Total _____ (Office Use)

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

_____

_____

Sexual Health Inventory:

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Be sure to select **only one** response per question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** _____