SONOMA NATUROPATHIC MEDICINE

Marcus Porrino, ND
Rebecca H. Porrino, ND
710 West Napa Street
Sonoma, CA 95476
Fax: 707-996-9356

FERTILITY HEALTH HISTORY

Female Name: _____
First Middle Initial Last Preferred name

Male Name: _____
First Middle Initial Last Preferred name

Address: _____

City: _____ State: _____ Zip code: _____

Contact numbers: home _____ work/cell: _____

Please **star the best phone # for appointment reminders and other messages – no health information will be disclosed.**

Female SS #: _____ Driver's license #: _____ Birth date: _____

Age: _____ Do you have any children yet you have: _____

Occupation: _____ Hours per week: _____

Male SS #: _____ Driver's license #: _____ Birth date: _____

Age: _____ Do you have any children yet? Y N If so, how many: _____

Occupation: _____ Hours per week: _____

Marital status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced

With whom do you live ☐ Alone ☐ Together/Spouse ☐ Separate ☐ Parents ☐ Friends ☐ Children

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Emergency contact: _____

Relationship: _____ **Telephone number:** _____

If someone other than patients is responsible for payment, please complete the following:

Name of responsible party: _____ SS#: _____

Relationship to patient: _____ Phone #: _____

In furnishing this information, I hereby grant contest for all treatments deemed necessary by the doctors of Sonoma Naturopathic Medicine for the purposes of wellness, prevention, or health care.

Signature: _____ **Date:** _____

How did you hear about our clinic _____

☐ Yes, please send me the quarterly newsletter: Email : _____

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HEALTH HISTORY QUESTIONNAIRE

Naturopathic healthcare is most effective when the doctor completely understands the patient's physical, mental, and emotional concerns and conditions. The information you provide helps me understand your needs and how to best help you reach your health goals. Your time, honesty, and thoughtfulness is appreciated. Feel free to mark anything you may have a question about.

Why did you choose to come to this clinic? _____

Are you currently seeing a gynecologist, GP or other fertility specialist? Y N

Have you undergone any treatment for fertility so far? Y N P

Are you currently taking fertility medications? Y N Past

If yes, whom and for how long? _____

_____

If no, when and where did you last receive medical or health care?

_____

What was the reason? _____

What three expectations do you have from **this** visit to our clinic?

What expectations do you have of me as your doctor?

What is your present **level of commitment** to addressing the underlying causes of your infertility? (Rate from 0 to 10-- 0 being little commitment, 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or habits do you engage in regularly that you believe **support** your health?

What behaviors or habits do you engage in regularly that you believe **do not support** your health?

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What each do you love to do?

EXPOSURES

	Female	Male
Current weight		
Recent weight-loss?		
Current height		
Occupation		

Mark with a Y or N in column	Female	Male
In the past 2 years, have you have frequent contact with chemicals including: solvents, paints, new carpets, new cars, manufacture of plastics, cooking in plastic, glues, insecticides, pesticides, frequent use of carbonless paper, hair colors or hair perming agents?		
Contact with heavy metals		
X-ray (dental or otherwise), MRI, or CAT scan (give dates if so)		
Use microwave		
Sleep near a fuse box		
Live or work near transmitter or power lines		
Often travel/commute during rush hour		
Currently, do you choose non-toxic personal care products (antipersirant, toothpaste, lotions, creams.) If yes, give brands.		
Exposure to second hand smoke? Past, currently?		
Do you buy organic food? If so, what percentage of food you eat is organic?> (Please consider eating out as well.)		
Do you wash your fruits and vegetables?		
Any known exposure to radiation or chemotherapy?		

Any family history of difficult conceiving? If so, who?

_____

REPRODUCTIVE HEALTH:

	Y	N
Have you already started trying to conceive? If yes, how long have you been trying? _____		
Have you had any prior conceptions? Male or Female --Please circle: live/ miscarriage/ stillborn/ termination/ premature/ small for dates/ or perinatal death --Give dates:_____ --Past conceptions with current partner?		
Has your current partner been responsible for any conceptions other than those above?		

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Were these conceptions with your current partner?		
Has your partner been responsible for other conceptions? If so, explain_____		

FEMALE REPRODUCTION/BREASTS

Age of first menses: _____
Length of cycle: _____ days
Duration of menses: _____ days
Are cycles regular Y P N

Bleeding between cycles Y P N
Date of last pap: _____
Abnormal PAP Y P N
Have you charted basal temperature Y N

	Y	P	N		Y	P	N
Ovarian cysts				Sexually transmitted disease			
Endometriosis				Herpes, warts			
Pelvic inflammatory disease				IUD			
PCOS				Menopausal symptoms			
Fibroids				Painful menses			
Yeast infections				Clotting during menses			
Bladder/Kidney infections				Heavy menstrual flow			
Abortion(s)				PMS			
Sexual difficulties				Pain during sex			
Nipple discharge				Unusual hair growth			
Recent weight gain				Difficulty loosing weight			
Headaches/migraines				Breast discharge/leaking			
Used birth control pill							

Exercise: _____ How often? _____

MALE REPRODUCTION

	Y	P	N		Y	P	N
Hernia				Unusual discharge			
Testicular pain				Unusual sores			
Sexually transmitted disease				Difficulty urinating			
Impotence				Epididymitis			
Premature ejaculation				Semen analysis			
Testicular masses				Blood test for hormones			
Prostate disease				Thyroid tests			
Examination of testes				Undecended testes			
Mumps in history				Use sauna, hot tubs often			
Style of underwear				Varicocele			

Exercise: _____ How often? _____

ALLERGIES

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Are you hypersensitive or allergic to:	Female	Male
Any medications		
Any foods:		
Other:		

CURRENT MEDICATIONS

Please ✓	Female	Male	Please ✓	Female	Male
Laxatives			Pain relievers		
Cortisone			Appetite suppressants		
Please ✓	**Female**	**Male**	**Please ✓**	**Female**	**Male**
Tranquilizers			Hormones		
Thyroid medication			Antacids		
Sleeping pills					

Please list **ANY other** prescription medications, over the counter medications, vitamins or other supplements you are taking: (Circle ♀=female partner, ♂=male partner)

1) ♀/♂_____ 4) ♀/♂_____
2) ♀/♂_____ 5) ♀/♂_____
3) ♀/♂_____ 6) ♀/♂_____

HABITS (Y = now, P = past, N = never)

Do you exercise? Y N If yes, what kind_____
How often _____
Spend time outside? Y N
How many **hours of sleep** do you get each night? _____

Sleep well	Y	P	N	Do you drink coffee	Y	P	N
Awaken rested	Y	P	N	Do you use tobacco	Y	P	N
Use recreational drugs	Y	P	N	Smoked previously	Y	P	N
Do you eat three meals a day	Y	P	N	Been treated for drug dependence	Y	P	N
Treated for alcoholism	Y	P	N	Use alcoholic beverages	Y	P	N
Do you go on diets often	Y	P	N	How often? _____			

REVIEW OF SYSTEMS

Have either of you suffered form any of these conditions?

a) **Major disease conditions**
   - □ Female
   - □ Male

b) **Mental emotional disease or neurologic?** (Anxiety, mood, depression, tension…)

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□ Female

□ Male

c) Cardio vascular/Heart disease? includes high blood pressure, angina, heart attack, poor circulation palpitations

□ Female

□ Male

d) Liver disease

□ Female

□ Male

e) Immune system, Autoimmune conditions (includes thyroid, chronic infections/colds, slow healing, Diabetes,)

□ Female

□ Male

DIGESTION:

Mark with a Y or N in column	Female	Male
Do you have daily bowel movements? If not, who and how often? _____		
Do you experience diarrhea / gas /belching / blood in stools / regular heartburn / indigestion/bloating / bad breath		
Have you been diagnosed with Irritable bowel syndrome or disease?		
Do you have food cravings		
Do you suffer from headaches		
On a 1 to 10 scale, rate your stress level (10 is highest stress possible.		
Do you sleep well		
Do you wake rested		
In general, is you energy	HIGH/MED/LOW	HIGH/MED/LOW
What time of day is your energy the highest		
When is your energy the lowest		

Are there any cultural or religious practices we should be aware of when providing healthcare to you? _____

Is there any information about your health you would like to add:

_____

_____

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Please return this intake form prior to your visit to:

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