DR. STEPHEN DALTON, D.O.
FAMILY MEDICINE

Infertility – Female Factor

Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Height _____

Address _____ City _____ State _____

Email _____ Phone _____

Do you smoke? **Y \ N**

Health concerns you'd like to address:

□ Weight loss / gain Target weight: _____

□ Increased fitness □ Optimal health □ Decrease GI symptoms

□ Increase athletic performance □ Increased energy □ Improve biochemical (lab) values

□ Decrease disease risk □ Improved sleep □ Improve blood pressure

□ Other _____

Do you suffer from any of the following conditions?

□ Liver cirrhosis □ Cystic fibrosis □ Kidney disease

□ Swallowing problems □ HIV positive

Please specific the type of work you do _____ How many days a week _____

Do you exercise? _____ If so, what kind?

1. Type of Exercise _____ How many times a week _____ for how long _____
2. Type of Exercise _____ How many times a week _____ for how long _____
3. Type of Exercise _____ How many times a week _____ for how long _____

Do you suffer from the following gastrointestinal conditions?

□ Crohn's disease □ Colitis □ Diarrhea □ H. Pylori

□ Constipation □ Candidiasis □ IBS □ Gas and bloating

Do you have food allergies, restrictions, or sensitivities? _____

_____

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Do you suffer from any of the following?

□ Hyperlipidemia	□ Coronary artery disease	□ previous heart-attacks
□ Statin intolerance	□ Osteoporosis	□ Clinical depression
□ Hemochromatitis	□ Chronic fatigue	□ Polycystic Ovarian Syndrome
□ Gallstones	□ Anorexia nervosa	□ Muscle cramps
□ Wilson's disease	□ Chronic cold	□ Kidney stones
□ Epilepsy	□ Hypothyroidism	□ Hyperthyroidism
□ Migraines	□ Heartburns or Acid reflux	□ Type I diabetes
□ Type II diabetes	□ Metformin flushing	□ Non-alcoholic fatty liver disease
□ PMS	□ Urinary tract infections	□ Mild cognitive impairment
□ Dysmenorrhea	□ Fibromyalgia	

If you suffered from any bone fractures in the last 3 years, which bone _____ when _____

Did you go through any of the following surgeries?

□ Stomach surgery	□ Small intestine surgery	□ Gall bladder surgery
□ Colon surgery	□ Heart surgery	□ Catheterization
□ Bariatric bypass	□ Bariatric sleeve	□ Bariatric gastric band

Do you have family history of the following conditions?

□ Type II diabetes	□ Hypertension	□ Cardiovascular disease
□ Colorectal cancer	□ Dementia / Alzheimer	

Do you take any nutritional supplements or vitamins? _____ If so, which ones? _____

_____

_____

Which prescription and over the counter medication do you take regularly? _____

_____

Fertility: Are you diagnosed with: □ Endometriosis □ Polycystic Ovarian Syndrome (PCOS)

Please fill in values of the following test if available:

AMH (anti-mullerian hormone) (ng/ml): _____

Day 3 FSH (Follicle stimulating hormone) level (mIU/ml): _____

Antral follicle count: _____

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3 DAY DIET RECALL

Record everything that you eat and drink. Be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating (i.e.: watching TV, driving, standing, talking etc…)

DAY 1 (*TYPICAL* ***WEEKDAY)***

BREAKFAST

_____
_____
_____
_____
_____
_____
_____
_____

MID-MORNING SNACK

_____
_____

LUNCH

_____
_____
_____
_____
_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DINNER

_____
_____
_____
_____
_____
_____
_____
_____

AFTER DINNER SNACK

_____
_____

DAY 2 (*TYPICAL* ***WEEKDAY)***

BREAKFAST

_____
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_____
_____
_____
_____
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_____

MID-MORNING SNACK

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_____

LUNCH

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_____
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_____

AFTERNOON SNACK

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_____

DINNER

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_____

AFTER DINNER SNACK

_____
_____

DAY 3 (*TYPICAL* ***WEEKEND)***

BREAKFAST

_____
_____
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_____

MID-MORNING SNACK

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LUNCH

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AFTERNOON SNACK

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DINNER

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AFTER DINNER SNACK

_____
_____

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QUESIONNAIRE FOR RATING PMS SYMPTOMS

Please rate each of the following symptoms, representing an average of the five days before menstruation, using the following rating scales:
0 = not present at all
1 = mild: only slightly apparent to you
2= moderate = aware of symptoms, but doesn't affect daily activity at all
3 = severe: continuously bothered by symptoms
4 = very severe: symptom is overwhelming and/or interferes with daily activity

Fatigue, lack of energy	
Poor coordination	
Feeling out of control, overwhelmed	
Feeling hopeless, worthless, or guilty	
Headache	
Anxiety, tension, "on edge"	
Aches	
Irritability, persistent anger	
Mood swings	
Swelling, bloating, weight gain	
Craving foods, increased appetite, overeating	
Decreased interest in usual activities	
Cramps	
Depression, feeling sad, down, or blue	
Breast tenderness	
Insomnia or hypersomnia	
Difficulty concentrating	