Supplementary Table 1

Nutrition Screening Form for Female Infertility Patients

This is a routine screening form that covers the role of diet and lifestyle in your general health.

Do you agree for our office to give this to our Registered Dietitian?

Yes___ NO___ (please initial) ____

Name: _____ DOB____ Age: ___ Date_____

Physician: _____ M/F married/single/partner

Weight History:

Ht: ____ Wt: ____ Highest adult wt: ____ (19) Lowest adult wt: ____ (19)

Comments: _____

What is your desired weight? _____

Have you ever been on a diet? □ yes □ no

If yes, explain type(s) of diet(s) and your success/outcome

_____

Physical Activity:

Activity Level: □ sedentary □ low □ mod □ active □ very active □ extremely active

What kind of physical activity? _____

How often do you exercise per week: ____x/wk @ _____ min/hr per session

Diet History:

I eat : □ 1 □ 2 □ 3 □ ___ meals/day and ___ snacks/day

I usually skip □ breakfast □ lunch □ dinner

I usually □ eat on the run □ pack own lunch/snacks □ prepare meals at home

□ eat out __x/day ___x/wk Who cooks at home?_____ Shops? _____

My style of eating is □ vegan □ semi-vegetarian □ lacto/ovo vegetarian (milk/eggs)

□ macrobiotic □ _____ culture/ethnic/religious background

□ low fat diet □ low fat/low cholesterol diet □ high vegetable/fruit diet

I avoid:

□ all animal products □ red meat □ chicken □ fish □ eggs □ milk/products

□ wheat/products □ fats/oils _____

□ citrus fruits □ others _____

I eat: red meat __x/wk __x/mo; poultry __x/wk __x/mo; fish __x/wk __x/mo

I eat legumes, tofu, other soy products __x/wk __x/mo; others _____

My favourite foods are: _____

My least favourite foods are: _____

□ I enjoy eating □ I feel guilty if I eat too much □ I do not enjoy eating

□ I have an eating disorder □ I had an eating disorder in the past (19 ___)

□ I have restricted my eating in the past _____

Fluid Intake: water ___c/day milk ___ c/day soymilk ___ c /day juice ___c/day

alcohol ____ /week (□ beer □ wine □ spirits (whiskey, gin, rum, vodka)

Coffee ___c/day colas ___c/day tea ___c/day herbal tea __c/day kind(s) _____

Note: c = cups 1 alcoholic drink = 12 oz beer, 5 oz wine, 1.5 oz spirits

Other lifestyle habits:

□ smoker ___/day for ___ yrs □ non-smoker quit ___ (19) Sleep ____hrs/day

□ other drugs _____ (marijuana, cocaine, steroids etc)

Do you take dietary Supplements? □ yes □ no

□ multivitamin □ calcium □ iron □ vit. C □ vit. E □ Vit A □ B-carotene

□ herbals □ anabolic steroids □ Growth hormone □ other supplements

Please list details below:

Brand name	type	Amount/pill	# taken/day

_____

□ I have **food sensitivities/allergies** (describe)_____

□ **Medications** (describe Over The Counter and Prescription):

_____

Stress

I would rate my stress level as:

- ☐ high
- ☐ high to moderate
- ☐ moderate
- ☐ low to moderate
- ☐ low

Comments: _____

I would like to make an appointment with the nutritionist/Registered Dietitian

to have a diet/lifestyle assessment for myself and/or partner ☐ yes ☐ no

For a complete nutrition assessment and lifestyle check make an appointment with the clinic dietitian/nutritionist. **A 3-day food record is requested for the initial visit**.