Name:_____
Date:_____

Infertility Nutrition Risk Screening

1. Have you been diagnosed with iron deficiency or turned away from donating blood due to low iron in the past year? Do you have restless legs syndrome?
   - ☐ Yes
   - ☐ No
   - ☐ Not tested

2. Have you been diagnosed with vitamin D deficiency in the past year?
   - ☐ Yes
   - ☐ No
   - ☐ Not tested

3. Do you have mouth sores inside your mouth (aka canker sores)?
   - ☐ Yes
   - ☐ No

4. Do you have dry, brittle hair?
   - ☐ Yes
   - ☐ No

5. Are you often tired or fatigued?
   - ☐ Yes
   - ☐ No

6. Do you have type 2 diabetes, insulin resistance, pre-diabetes or polycystic ovarian syndrome? Have you had gestational diabetes?
   - ☐ Yes
   - ☐ No
   - ☐ Not tested

7. Do you have endometriosis, fibroids or poor quality oocytes (eggs)?
   - ☐ Yes
   - ☐ No
   - ☐ Not tested

8. Do you have a history of miscarriages?
   - ☐ Yes
   - ☐ No

9. Do you have depression or anxiety?
   - ☐ Yes
   - ☐ No

10. How often do you feel out of control of your food choices?
    - ☐ Often
    - ☐ Occasionally
    - ☐ Rarely

11. How often do you restrict your food intake to control your weight?
    - ☐ Often
    - ☐ Occasionally
    - ☐ Rarely

12. Are you an emotional eater?
    - ☐ Yes
    - ☐ No

13. Are you actively trying to gain or lose weight right now?
    - ☐ Yes
    - ☐ No

14. Have you gained or lost more than 10 pounds in the past 6 months?
    - ☐ Yes
    - ☐ No
    - ☐ Not sure

15. Have you ever had an eating disorder?
    - ☐ Yes
    - ☐ No

16. How often do you eat vegetables with at least two meals daily?
    - ☐ Often
    - ☐ Occasionally
    - ☐ Rarely

17. How often do you eat outside of your home?
    - ☐ Multiple times daily
    - ☐ Daily
    - ☐ Weekly
    - ☐ Monthly
    - ☐ Rarely

18. How often do you eat standing up, in the car, or while reading, working or watching television?
    - ☐ Most meals
    - ☐ Occasionally
    - ☐ Rarely

19. Are you currently following any specific diet (e.g., low carbohydrate, Paleo, elimination diet, calorie counting, portion controlled etc)?
    - ☐ Yes
    - ☐ No

20. Are you taking a prenatal supplement?
    - ☐ Yes
    - ☐ No