Anova Fertility & REPRODUCTIVE HEALTH
TODAY'S TECHNOLOGY. TOMORROW'S HOPE.

NEW PATIENT INTAKE FORM
SAME SEX FEMALE

PATIENT INFORMATION

FIRST Name: LAST Name: MIDDLE Initial:

Health Card #: Version Code:
Expiry Date:
Sex: Male Female Marital Status:
Other* - Please refer to me as:
Date of Birth: Age:
Occupation:

Home Phone #:
Cell Phone #:
Email Address:
Skype ID:

Address:
City: Province Postal Code

Are you prepared to have all medical visits at ANOVA? Yes No

If not, please provide the clinic information as to where you will be seen below.
Clinic Name:
Contact Person:
Email:
Phone Number:
Fax Number:

PARTNER INFORMATION (If applicable)

FIRST Name: LAST Name: MIDDLE Initial:

Health Card #: Version Code:
Expiry Date:
Sex: Male Female Marital Status:
Other* - Please refer to me as:
Date of Birth: Age:
Occupation:

Contact #:
Email Address:
Skype ID:

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
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Please complete if address no same as patient's.

Address:

City: Province Postal Code

***Please note that Anova Fertility is LGBTQ inclusive and your medical history may require us to make reference to the gender you were assigned to at birth.**

How did you hear about us?

- Referring Physician
- Cityline
- Social Media
- Other:

I agree that the relationship between Anova Fertility and me will be governed and construed in accordance with the laws of the province of Ontario and that the courts of the province of Ontario will have sole jurisdiction to hear any complaints whatsoever.

I agree and consent to Anova Fertility & Reproductive Health whom is a health information recipient of the eHealth Ontario (Connecting Ontario) to access medical records from participatory hospitals and health information contributors.

I consent to receive communication from Anova Fertility and its affiliated subsidiaries through electronic email.

Patient Name	Patient Signature	Witness Signature	YYYY/MM/DD

Partner Name	Partner Signature	Witness Signature	YYYY/MM/DD

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PATIENT MEDICAL HISTORY

Height: inches *or* cm Weight: lbs *or* kgs

Please list the medications you are taking on a regular basis:

Are you taking folic acid or a prenatal vitamin: Yes No

Are you currently on any form of birth control? Yes No

When are you expecting your next period?

Are you sexually active? Yes No

Menstrual History

How old were you when you first had your period?

When was the first day of your last menstrual period?

Are your periods regular? Yes No If no, what is the longest time you did not have a period

On average, how many days between your periods?

How long do your periods last?

Gynecological History

Do you have any history of sexually transmitted diseases (STDs) ? Yes No
If yes, explain:

When was your last PAP Smear? Was it normal? Yes No

Did you have any treatment on the cervix? Yes No
If yes, explain:

Have you ever used any birth control or contraception in the past? Yes No
If yes, explain:

Obstetric History

Have you ever been pregnant? No Yes
(please provide details of your pregnancies: Date of birth / vaginal or caesarean / boy or girl / at term / how long did it take to become pregnant)

If you have experienced miscarriages, please provide details of your miscarriages:
(date / surgery needed or not / how many weeks? / how long did it take to become pregnant?)

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If you have ever had an elective abortion, please provide details:

Have you previously used a Gestational Carrier to achieve pregnancy? Yes No

Past Medical History

Do you have any chronic medical conditions? If yes, please provide details:

Have you had any surgery in the past? If yes, please provide details:

Family History (please specify mother's side or father's side)

Is there any family history of genetic disease? (ie. Cystic fibrosis, Down syndrome, Sickle Cell disease, etc)

Social History

Do you smoke? Yes No If yes, how many cigarettes per day?

Do you drink alcohol? Yes No If yes, how many drinks per week?

Do you do any recreational drugs? Yes No
If yes, explain:

Are you and your partner related by blood? Yes No

What is your ethnic background?

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(please provide details of your pregnancies: Date of birth / vaginal or caesarean / boy or girl / at term / how long did it take to become pregnant)

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(date / surgery needed or not / how many weeks? / how long did it take to become pregnant?)

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