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

NEW PATIENT INTAKE FORM
SAME SEX MALE

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

Ver 20190117-SSM-A

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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: _____ centimeters Weight: _____ kgs

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

Are you sexually active? ☐ Yes ☐ No

Past Medical History

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

_____

Have you had any surgery/injury involving your testicles? 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? _____

Have you ever fathered a child: ☐ Yes ☐ No

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

If yes, please provide the details of the pregnancies below
(date of birth / vaginal or caesarean / boy or girl / at term / complications)

_____

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NEW PATIENT INTAKE FORM
SAME SEX MALE

PARTNER MEDICAL HISTORY

Height: centimeters Weight: kgs

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

Are you sexually active? Yes No

Past Medical History

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

Have you had any surgery/injury involving your testicles? 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?

Have you ever fathered a child: Yes No

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

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