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

NEW PATIENT INTAKE FORM

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 #:

__ Other Phone #:

*Please check off the best number you can be contacted at with voicemail.

Address:

City: Province Postal Code

Referred Physician: Family Physician:

Allergies:

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:

__ Home Phone #:

__ Cell Phone #:

__ Other Phone #:

*Please check off the best number you can be contacted at with voicemail.

Please complete if address no same as patient's.

Address:

City: Province Postal Code

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
©2019 Anova Fertility and Reproductive Health. All Rights Reserved.
Reproduction in whole or in part without prior written permission is prohibited.
Ver 20190117-A

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

NEW PATIENT INTAKE FORM

***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.**

Referred Physician:	Family Physician:
Allergies:	

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

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
©2019 Anova Fertility and Reproductive Health. All Rights Reserved.
Reproduction in whole or in part without prior written permission is prohibited.

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

NEW PATIENT INTAKE FORM

FEMALE MEDICAL HISTORY

NAME:

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

1. Are you trying to conceive? If so, for how long?
2. Please list the medications you are taking on a regular basis:

Menstrual History

1. How old were you when you first had your period?
2. When was the first day of your last menstrual period?
3. Are your periods regular? Yes No If no, what is the longest time you did not have a period
4. On average, how many days between your periods?
5. How long do your periods last?
6. Please state your menstrual flow: Normal Light Heavy
7. Do you ever have clots during your period? Yes No
8. Do you experience pain with your periods? None Mild Moderate Severe
9. Do you take medication for the pain? Yes No If yes, what medication(s):
10. Before your periods, do you have (check all that apply):

    Cramps Breast Tenderness Bloating Mood Changes

Gynecological History

1. Do you have any history of sexually transmitted diseases (STDs) ? Yes No

   If yes, explain:
2. When was your last PAP Smear? Was it normal? Yes No
3. Did you have any treatment on the cervix? Yes No

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

   If yes, explain:
5. If applicable, do you have pain with intercourse? Yes No

   If yes, is it: Initial Deep
6. If applicable, how often per week do you have intercourse?

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
©2019 Anova Fertility and Reproductive Health. All Rights Reserved.
Reproduction in whole or in part without prior written permission is prohibited.

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?)

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

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:

Do you have acne? Yes No

Do you have excess hair growth on your body? Yes No

Do you have any visual changes where you can't see certain parts of your visual field? Yes No

If yes, explain:

Do you have any discharge from your nipples? Yes No

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
©2019 Anova Fertility and Reproductive Health. All Rights Reserved.
Reproduction in whole or in part without prior written permission is prohibited.

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

NEW PATIENT INTAKE FORM

MALE MEDICAL HISTORY

NAME:

1. Are you trying to conceive? If so, for how long?
2. Please list the medications you are taking on a regular basis?

Genito-Urinary History

1. Have you ever conceived before? Yes No
2. If yes, was it in your current relationship? Yes No
3. What was the outcome of the pregnancy?
4. Do you have any children? Yes No If yes, how many and how old:
5. Is your partner their biological parent? Yes No
6. Do you have any history of sexually transmitted diseases (STDs)? Yes No
   If yes, explain:
7. Do you have a history of undescended testicles? Yes No
8. Have you ever had an injury to your testicles? Yes No
9. Have you ever had inflammation of your testicles from mumps? Yes No
10. Do you have any occupational exposure to toxins, heat, or radiation? Yes No
    If yes, explain:
11. Do you have a history of genital infections? (ie. Prostatitis) Yes No
    If yes, explain:
12. Have you ever had any surgery on your genitals or hernia repair? Yes No
    If yes, explain:
13. Do you have any trouble with erections or ejaculations? Yes No
    If yes, explain:
14. Do you use hot tubs on a regular basis? Yes No
15. Are you taking any hormonal supplements? Yes No

Past Medical History

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

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
©2019 Anova Fertility and Reproductive Health. All Rights Reserved.
Reproduction in whole or in part without prior written permission is prohibited.
Ver 20190117-A

NEW PATIENT INTAKE FORM

Did you have any past surgery? 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)

Height / Weight

What is your height? (feet) What is your weight? (lbs)

Social History

1. Do you smoke? Yes No If yes, how many cigarettes per day?
2. Do you drink alcohol? Yes No If yes, how many drinks per week?
3. Do you do any recreational drugs? Yes No
   If yes, explain:
4. Are you and your partner related by blood? Yes No
5. What is your ethnic background?

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com
©2019 Anova Fertility and Reproductive Health. All Rights Reserved.
Reproduction in whole or in part without prior written permission is prohibited.
Ver 20190117-A