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

NEW PATIENT INTAKE FORM
THIRD PARTY

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

Referred Physician: Family Physician:

Allergies:

Note: If you have a partner, they are required to have blood work done as part of your screening.

PARTNER INFORMATION (If applicable)

No Partner

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:

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.**

Suite 650 – Sheppard Ave W., Toronto, ON M2N 6S6 tel: (416) 225-4440 fax: (416) 640-9454 anovafertility.com

Ver 20190117-3P-A

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NEW PATIENT INTAKE FORM
THIRD PARTY

Referred Physician:	Family Physician:
Allergies:	

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

If no, please provide the clinic information as to where you will be seen below.

Clinic Name:

Contact Person:

Email:

Phone Number:

Fax number:

Do you plan to use an Egg Donor or Surrogate? ☐ No ☐ Egg Donor ☐ Surrogate ☐ Unsure

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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FEMALE MEDICAL HISTORY

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:

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?

Previous Donation / Gestational Carrier

How many times have you been an egg donor? Times.

Please provide details of previous donations: (Dates, Clinic, Agency, etc)

How many times have you been a Gestational Carrier? Times.
(Please provide details of the pregnancies you've carried below if not stated above)

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PARTNER MEDICAL HISTORY

☐ Not Applicable

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

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 in the past 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

Was the pregnancy with your current partner? ☐ Yes ☐ No

If no, please provide the details of the pregnancies below.
(date of birth / vaginal or caesarean / boy or girl / at term / how long did it take to become pregnant / complications)

_____

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