

Care Fertility & Women's Health

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New Patient Intake Form (Care Fertility & Women's Health)

Please complete this form to help us provide you with the best possible care. All information is confidential and will be used solely for your medical care.

Date: _____

Demographics

Last Name *

First Name *

Nickname / Preferred Name

Gender *

Female

Male

Date of Birth *

___ / ___ / _____ (yyyy / mm / dd)

Health Card Number (OHIP or other)

Health Card Version Code (last 2 letters if OHIP)

Contact Information

Address

Cell Phone Number *

Email Address *

Preferred Language

- English
- French

Referral Information

Referring Physician with Contact Information

Family Doctor Name and Contact (if different from above)

Medical History

Height (ft)

Height (in)

Height (cm)

Weight (kg)

Weight (lbs)

Reason for Visit / Chief Complaint *

How long have you been trying to conceive? (if applicable)

Previous Fertility Treatments (if any)

Gynecologic History

Age at First Period (Menarche)

Menstrual Cycle Length (if irregular, specify shortest to longest)

Menstruation duration (days)

Date of Last Menstrual Period (LMP)

____ / ____ / _____ (yyyy / mm / dd)

Age of menopause (last menstruations) if applicable

Do you experience painful periods?

- None
- Mild
- Moderate
- Severe

Are you virgin (i.e. never had a vaginal penetration)?

- Yes
- No
- I'm not sure

Do you experience pain during sex ?

- None
- Mild
- Moderate
- Severe
- Sometimes

Date of Last Pap Smear

___ / ___ / _____ (yyyy / mm / dd)

Last Pap Smear Result

Last Mammogram date

___ / ___ / _____ (yyyy / mm / dd)

Last Mammogram result

Pregnancy History

Total Number of Pregnancies

Number of Vaginal Births

Number of cesarean sections

Number of Miscarriages

Number of Ectopic Pregnancies

Number of Elective abortions

Pregnancy Details (if applicable)

Medical History

Past Medical Conditions and Present chronic illnesses

Past Surgeries

Family Medical History

Allergies

Current Medications

Non-prescription products (vitamins, supplements, etc...)

Social History

Occupation

How many cigarettes do you smoke? (per day or week)

Alcohol: how many drinks do you have per week ?

Recreational Drug Use?

Exercise Frequency

Partner Information (if applicable)

Partner's Name

Partner's Date of Birth

____ / ____ / _____ (yyyy / mm / dd)

Partner's Phone Number

Partner's Email

Additional Information

How did you hear about us?

- Physician Referral
- Friend/Family
- Online Search
- Social Media
- Other

Is there anything else you would like us to know?

I confirm that the information provided is accurate to the best of my knowledge *

- Yes
- No