



This is a 3 part questionnaire consisting of:

- Part 1: Contact Information
- Part 2: Female Partner's Medical History
- Part 3: Male/Partner's Medical History (where applicable)

Please be as accurate and detailed as possible in filling out all information, as this form will become part of your medical history. Thank-you.

### Contact Information

#### Female/Patient

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Age** \_\_\_\_\_  
(as it appears on Health Card) (as it appears on Health Card)

Date of Birth (DD/MM/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

**OHIP (with Version Code)/RAMQ/Military Number** \_\_\_\_\_  
 (Please note: Quebec patients must pay physician directly but please provide number for lab)

Address \_\_\_\_\_ City \_\_\_\_\_

Province/State \_\_\_\_\_ Postal/Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work/Cell) \_\_\_\_\_ Ext \_\_\_\_\_

Which Number (if any) is best to leave messages \_\_\_\_\_

#### Male/Spouse/Partner

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Age** \_\_\_\_\_  
(as it appears on Health Card) (as it appears on Health Card)

Date of Birth (DD/MM/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

**OHIP (with version code)/RAMQ/Military Number** \_\_\_\_\_  
 (Please note: Quebec patients must pay physician directly but please provide number for lab)

Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_

Province/State \_\_\_\_\_ Postal/Zip Code \_\_\_\_\_ Country \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work/Cell) \_\_\_\_\_ Ext \_\_\_\_\_

Which Number (if any) is best to leave messages \_\_\_\_\_

#### Who is your Referring Physician?

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_