Baby Steps Fertility Clinic

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Patient Registrstion Form

Name

First Name | Last Name

Nick Name

First Name | Last Name

Date of Birth | Sex

Date

Height (cm) | Weight (kg)

Marital Status

Contact Number: | E-mail

Address:

Street Address

City

State / Province

Postal / Zip Code

Are You currently taking any medication?

- Yes
- No

If so, please list_____

Do You have any medication allergies?

- Yes
- No

Do You use or do you have history of using tabacco?

- Yes
- No

How often do you consume alcohol?

- Daily
- Weekly
- Monthly
- Occasionally
- Never

How healthy do you feel in general?

0 5 10

Remarks (only for clinic use)

Patient Name & Signature

Date

Doctor Name & Stamp

Date

(Clinic use only)