



Women's Health Clinic TA Questionnaire

Date of Appointment inquiry: _____

Name: _____

Address: _____

Allergies: _____

Health Card Number: _____

Phone Number: _____ Can we leave a message? Yes / No

Do you prefer email communication or phone call: Email / Phone

Who referred you (can be self): _____

Last Menstrual Period (LMP): _____

Date of Positive pregnancy test: _____

Have you had an ultrasound? Yes / No

If yes, date: _____

Have you had a previous Termination: Yes / No

Are you looking to book a medical or surgical termination? Medical / Surgical

Do you need more information? _____