Patient Identification

RAMQ
First Name
Last Name
Date of Birth (YYYY/MM/DD)
Hospital Card Number

PHYSICAL EXAM

Examination	Normal	Abnormal (describe abnormality)
Blood Pressure		
BMI		
Thyroid		
Respiratory		
Cardiovascular		
Abdominal		

200-888 boul de Maisonneuve E Montréal QC H2L 4S8 CANADA
Tél 514 843-1650 Fax 514 843-1496 fertility@muhc.mcgill.ca muhc.ca/reproductivecentre

Examination	Normal	Abnormal (describe abnormality)
Pelvic		
Cervix/vaginal mucosa		
PAP (if indicated)		
Cervix exam		

Exam Date: _____

Examined by: _____ License: _____

Signature: _____

Please fax results to 514-843-1496.

200-888 boul de Maisonneuve E Montréal QC H2L 4S8 CANADA
Tél 514 843-1650 Fax 514 843-1496 fertility@muhc.mcgill.ca muhc.ca/reproductivecentre