Marjon C. Blouw MD, CCFP, FCFP

Bayside Medical Services Inc. MSP Practitioner # 905

#101 – 1964 Fort St.
Victoria, B.C. V8R 6R3

Voice Mail: 250 721 9494
Fax: 250 721 4503

Date: _____

Name of Patient: _____ PHN: _____

Age: _____ Gender: _____ Date of Birth: Month ____ Day ____ Year ____

Phone: Home _____ Cell phone: _____

Email Address: _____

Address: _____

Referring Physician/Nurse Practitioner: Name _____

Physician Address: _____

GP/FP ___; NP ___; Gynecologist ___; Urologist ___; Psychiatrist ___; Other _____

Billing number: _____

Telephone: _____ Fax: _____ Private line: _____

Please include:
*Medical, Surgical, Psychiatric History

*Lab results
*Previous treatments for sexual concerns

*Relevant Consultation Letters
*Current Medications and Allergies

Types of Sexual Difficulties/Concerns:
Pain ___ Arousal/ED ___ Drive ___ Orgasm ___ Ejaculation ___ Couple Communication ___
Satisfaction ___

Your diagnosis:

If you are referring the partner as well, please fill out a separate sheet with relevant information. Thank you.