PATIENT INFORMATION

Date: _____

Name: _____

Last First Middle

Date of Birth: _____ Age: _____ Primary Language: _____

Patient's Social Security #: _____

Home address: _____

City, State, Zip Code: _____

Primary phone: _____ Alternate Phone: _____

Email address: _____

Ethnicity/Race: _____

Marital Status: _____ Single _____ Married _____Widowed _____Divorced _____Separated

Employer: _____ Occupation: _____

Partner/Father of baby: _____ Phone: _____

Partner/Father of baby's age: _____ Partner/Father of baby's Race/Ethnicity: _____

Partner/Father of baby's Employer/Occupation: _____

Emergency Contact: _____ Phone: _____

Referring OB: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID#: _____ Group #: _____

Secondary Insurance Company: _____

ID#: _____ Group #: _____

MEDICAL HEALTH HISTORY

Name: _____

Age _____Date of birth _____Due Date _____

Height _____ feet _____inches Current weight _____ Pre-pregnancy weight _____

Pharmacy _____ Rx phone & Address _____

PREGNANCY HISTORY (Live birth, miscarriages, terminations)

MM/YR	Weeks at delivery	Baby Weight	Vaginal or C-section	Sex	Preterm Labor	Gestational diabetes	Birth defects	High blood pressure	Complications
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	
					Y / N	Y / N	Y / N	Y / N	

MM/YR	
	□Miscarriage □Termination □Ectopic _____ Wks Pregnant D&C Y / N
	□Miscarriage □Termination □Ectopic _____ Wks Pregnant D&C Y / N
	□Miscarriage □Termination □Ectopic _____ Wks Pregnant D&C Y / N

GYNECOLOGICAL HISTORY

1st Day of Last Period _____ Regular cycles Y /N

History of Sexually Transmitted Infection: Y / N

Circle applicable: HIV/ Chlamydia/ Gonorrhea/ Syphilis/ Herpes/ HPV/ Trichomonas

Use of fertility treatment this pregnancy? Y / N

Circle applicable: Clomid/ IVF/ IUI or ovulation induction/ ICSI

MEDICATIONS/DRUGS/ALLERGIES

Are you taking any medications (prescriptions, vitamins, herbs, alternative medications, over the counter)? Y /N.

If so, please list all with dosages: _____

_____

_____

_____

Do you have any medication, latex, or drug allergies? Y /N. If so, please list below with reactions:

_____

_____

FAMILY AND GENETIC HISTORY

Do you, your partner, or close relative have any of the following? If yes, please explain:

	Self	Family	No	Who & Explain
Anemia/Thalassemia				
Spina bifida (open spine)				
Heart problems from birth				
Down Syndrome/Fragile X				
Tay-Sachs disease (Jewish)				
Sickle cell disease or trait				
Clotting/bleeding disorders (hemophilia)				
Muscular dystrophy				
Spinal muscular atrophy				
Cystic fibrosis				
Three or more miscarriages				
Canavan disease (Jewish)				
Mental delay/autism/learning disorder				
Hydrocephalus (water on the brain)				
Hearing loss or deafness from childhood				
Cancer				
Polycystic kidneys				
Diabetes				
Hypertension/stroke				
Blood clots in lungs or legs				
Stillbirth or infant death				
Cleft lip or palate				
Blindness from childhood				
Clubbed feet				
Other birth defects				

Do you have any other health concerns in your family or the baby's father's family? Y /N

If yes, please explain: _____

Are you interested in obtaining information on cystic fibrosis? It is a chronic disease that is more common in individuals of European ancestry that affects the respiratory, digestive, and reproductive systems. Y / N.

Are you interested in obtaining information on fragile X syndrome? It is a disease that causes developmental and mental delay, autism, and hyperactivity. Y / N.

Are you interested in obtaining information on spinal muscular atrophy? It is a rare disease that causes infants or children to lose muscle control over their body. Y / N.

You may be a carrier of the above diseases and not be aware of it. We have information regarding the above medical conditions and screening. **Please check with your individual insurance company to see if they will cover screening for the above medical conditions.**

SOCIAL HISTORY

Please check if any of the following apply

	No	Current	Past	How long quit	How much/often
Tobacco					
Alcohol					
Street drugs					
Other					

Medical History

	Self	Family	No	Who & Explain
Vision/hearing				
Asthma				
Tuberculosis or close contact				
Heart problems (murmurs, palpitations, circulation)				
Pulmonary embolus or deep venous thrombosis				
Hypertension				
Nausea/vomiting/diarrhea/constipation				
Intestinal problems/Colitis/Ulcers				
Hepatitis				
Liver problems				
Bladder/kidney/urinary infections				
Diabetes				
Seizure/Migraines				
Depression/anxiety				
Thyroid problems				
Joint pain/arthritis				
Lupus/anti-phospholipid syndrome				
Blood transfusion				

Surgical History:

Year: _____ Type of surgery: _____

Year: _____ Type of surgery: _____

Explain any surgical complications: _____