

Name: First Middle Last			Today's date	Occupation/Type of Business
Race	Marital status	Phone (home / work / cell)	Date of Birth	State of Birth
Address: Street City Zip			Email	
Partner's Name: First Middle Last			Race	Date of Birth
Address (if different from above)			Phone (home / work / cell)	Occupation/Type of Business
Father of Baby (if different from Partner)		Race	Another person to contact in emergency	
			Name:	Relationship: Phone:
Method of Payment: <input type="checkbox"/> Insurance		Name:		Relationship: Phone:
<input type="checkbox"/> Medicaid (Healthy Start) <input type="checkbox"/> Cash				
Social Security Number	Husband's Social Security Number		How did you find out about us?	

Please answer the following questions which will help us determine if there are potential problems we should discuss further for the safety of you and your baby. This information is completely confidential.

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? Yes No Feelings about pregnancy _____

Planned pregnancy Yes No Partner's feelings _____

Suspected date of conception _____ Contraception used in past; what, when, any problems? _____

Pregnancy test (date) _____ Most recent birth control used _____

Please indicate if you have had any of the following during this pregnancy:

<input type="checkbox"/> Nausea _____	<input type="checkbox"/> Leg cramps _____	<input type="checkbox"/> Urinary complaints _____	<input type="checkbox"/> Work problems _____
<input type="checkbox"/> Vomiting _____	<input type="checkbox"/> Rash _____	<input type="checkbox"/> Abdominal / pelvic pain _____	<input type="checkbox"/> Loneliness _____
<input type="checkbox"/> Fever _____	<input type="checkbox"/> Backache _____	<input type="checkbox"/> Vaginal bleeding / spotting _____	<input type="checkbox"/> Family/relationship problems _____
<input type="checkbox"/> Infections _____	<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Vaginal discharge _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Headache _____	<input type="checkbox"/> Constipation _____	<input type="checkbox"/> Hemorrhoids _____	
<input type="checkbox"/> Dizziness _____	<input type="checkbox"/> Diarrhea _____	<input type="checkbox"/> Varicose veins _____	
<input type="checkbox"/> Indigestion _____	<input type="checkbox"/> Bleeding gums _____	<input type="checkbox"/> Depression _____	

Please indicate if you have used, experienced or been exposed to any of the following during this pregnancy:

<input type="checkbox"/> Tobacco _____	<input type="checkbox"/> Non-pres.meds _____	<input type="checkbox"/> Fumes / sprays _____	<input type="checkbox"/> Vaccinations _____
<input type="checkbox"/> Alcohol _____	<input type="checkbox"/> Prescr. meds _____	<input type="checkbox"/> X-rays _____	<input type="checkbox"/> Cats _____
<input type="checkbox"/> Marijuana _____	<input type="checkbox"/> Vitamins _____	<input type="checkbox"/> Ultrasound _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cocaine _____	<input type="checkbox"/> Herbs _____	<input type="checkbox"/> Measles / Viruses _____	
<input type="checkbox"/> Other drugs _____		<input type="checkbox"/> Travel _____	

GYNECOLOGIC HISTORY

Age at first period _____ Cycle length (days) _____ Regular? Yes No # of days your period typically lasts _____

When was your last Pap smear? _____ Have you ever had an abnormal Pap? (dates) _____ Please describe _____

Please indicate if you have had any of the following and when:

<input type="checkbox"/> Yeast _____	<input type="checkbox"/> Syphilis _____	<input type="checkbox"/> Cervical surgery _____	<input type="checkbox"/> Uterine surgery _____
<input type="checkbox"/> Trichomonas _____	<input type="checkbox"/> PID / Pelvic infection _____	<input type="checkbox"/> Cervical polyp _____	<input type="checkbox"/> Breast lump(s) _____
<input type="checkbox"/> Group B Strep _____	<input type="checkbox"/> Genital sores _____	<input type="checkbox"/> Ovarian cyst _____	<input type="checkbox"/> Breast surgery _____
<input type="checkbox"/> Bacterial vaginosis _____	<input type="checkbox"/> Herpes <input type="checkbox"/> Genital <input type="checkbox"/> Oral	<input type="checkbox"/> Fibroids _____	<input type="checkbox"/> Infertility _____
<input type="checkbox"/> Chlamydia _____	<input type="checkbox"/> Condyloma (warts) _____	<input type="checkbox"/> Endometriosis _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Gonorrhea _____	<input type="checkbox"/> Cervicitis _____	<input type="checkbox"/> Abnormal bleeding _____	

PREVIOUS PREGNANCIES Please complete this table regarding your own pregnancies (from earliest to most recent)

	Date	Birth / Miscarriage / Termination	# Weeks	Name	Sex	Weight	Hours Labor	Meds	Complications	Location
1										
2										
3										
4										
5										

MEDICAL HISTORY Please indicate if you have ever had any of these and when **Allergies:** _____

<input type="checkbox"/> Severe headaches _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Bowel problems / colitis _____	<input type="checkbox"/> Urinary tract infection _____
<input type="checkbox"/> Eye / vision problems _____	<input type="checkbox"/> Varicose veins _____	<input type="checkbox"/> Blood in stool _____	<input type="checkbox"/> Urethral dilation _____
<input type="checkbox"/> Ear / hearing problems _____	<input type="checkbox"/> Hemorrhoids _____	<input type="checkbox"/> Gall bladder problems _____	<input type="checkbox"/> Aching joints _____
<input type="checkbox"/> Dental problems _____	<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Liver problems _____	<input type="checkbox"/> Pelvic / back injuries _____
<input type="checkbox"/> Thyroid problems _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Skin disorders _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Blood clotting problems _____	<input type="checkbox"/> Stomach problems _____	<input type="checkbox"/> Hypoglycemia _____	<input type="checkbox"/> Hospitalizations _____
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Ulcers _____	<input type="checkbox"/> Bladder infection _____	<input type="checkbox"/> Surgeries _____
<input type="checkbox"/> Hemorrhage _____	<input type="checkbox"/> Chicken pox _____	<input type="checkbox"/> Kidney infection _____	<input type="checkbox"/> Other _____

Family history – Indicate if anyone in your immediate family has ever had any of these, who, when.	Father of Baby – Indicate if the baby's father has ever had any of these; when.	Your Mother's History – Please answer the following regarding your mother:
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Sexually transmitted diseases _____	<input type="checkbox"/> No. of pregnancies _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Herpes <input type="checkbox"/> Genital <input type="checkbox"/> Oral	<input type="checkbox"/> No. of births _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Severe emotional problems _____	<input type="checkbox"/> Miscarriages _____
<input type="checkbox"/> Twins _____	<input type="checkbox"/> Alcohol/Drug abuse _____	<input type="checkbox"/> Your weight at birth _____
<input type="checkbox"/> Severe emotional problems _____	<input type="checkbox"/> Tobacco use _____	<input type="checkbox"/> Any complications _____
<input type="checkbox"/> Alcohol/Drug abuse _____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Other _____	_____	_____

- Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
- Yes No Do you or the FOB have any family member with birth defects or conditions diagnosed as genetic or inherited?
- Yes No Are you and the FOB related by blood? (e.g., cousins)
- Yes No Are you or the FOB from any of these ethnic / racial groups ? Jewish Black/African Asian Mediterranean
- Yes No Have you or the FOB ever had hepatitis or jaundice?
- Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?
- Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
- Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
- Yes No Do you think you are at increased risk for AIDS / HIV?
- Yes No Have you ever experienced dramatic fluctuations in your weight?
- Yes No Have you ever had anorexia, bulimia or other eating problems?
- Yes No Is there anything about the development of your sexuality that you'd like to discuss?
- Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
- Yes No Have you ever had severe emotional problems?
- Yes No Have you ever been on any medication for psychological problems?
- Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

Please give brief directions to your home, including intersections and landmarks _____

