CLIENT REGISTRATION

Name: First Middle Initial 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 Initial Last				Race	Date of Birth	State 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: Name: Relationship: Phone:			
Method of Payment: ☐ Insurance ☐ Medicaid (BadgerCare) ☐ 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

Planned pregnancy ☐ Yes ☐ No

Suspected date of conception________________________________

Pregnancy test (date) ______________________________________

Feelings about pregnancy____

Partner's feelings____

Contraception used in past; what, when, any problems?_________________________________ __________

____

Most recent birth control used____

Please indicate if you have had any of the following during this pregnancy (and comment if necessary):

☐ Nausea________________________	☐ Leg cramps_____________________	☐ Urinary complaints________________	☐ Work problems__________________
☐ Vomiting_______________________	☐ Rash__________________________	☐ Abdominal / pelvic pain____________	☐ Loneliness______________________
☐ Fever_________________________	☐ Backache_______________________	☐ Vaginal bleeding / spotting_________	☐ Family/relationship problems________
☐ Infections______________________	☐ Swelling________________________	☐ Vaginal discharge________________	__________________________________
☐ Headache______________________	☐ Constipation_____________________	☐ Hemorrhoids_____________________	☐ Other___________________________
☐ Dizziness______________________	☐ Diarrhea________________________	☐ Varicose veins___________________	__________________________________
☐ Indigestion_____________________	☐ Bleeding gums___________________	☐ Depression_____________________	__________________________________

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

☐ Tobacco_______________________	☐ Non-pres.meds__________________	☐ Fumes / sprays__________________	☐ Vaccinations_____________________
☐ Alcohol________________________	☐ Prescr. meds __________________	☐ X-rays__________________________	☐ Cats____________________________
☐ Marijuana______________________	☐ Vitamins________________________	☐ Ultrasound_______________________	☐ Other___________________________
☐ Cocaine________________________	☐ Herbs__________________________	☐ Measles / Viruses________________	__________________________________
☐ Other drugs_____________________		☐ 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:

☐ Yeast__________________________	☐ Syphilis_________________________	☐ Cervical surgery__________________	☐ Uterine surgery___________________
☐ Trichomonas____________________	☐ PID / Pelvic infection_____________	☐ Cervical polyp____________________	☐ Breast lump(s)____________________
☐ Group B Strep___________________	☐ Genital sores____________________	☐ Ovarian cyst_____________________	☐ Breast surgery____________________
☐ Bacterial vaginosis_______________	☐ Herpes ☐ Genital ☐ Oral	☐ Fibroids_________________________	☐ Infertility_________________________
☐ Chlamydia______________________	☐ Condyloma (warts)________________	☐ Endometriosis____________________	☐ Other____________________________
☐ Gonorrhea______________________	☐ Cervicitis_______________________	☐ Abnormal bleeding________________	___________________________________

CLIENT REGISTRATION

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: ____

☐ Severe headaches________________	☐ High blood pressure________________	☐ Bowel problems / colitis______________	☐ Urinary tract infection______________
☐ Eye / vision problems______________	☐ Varicose veins____________________	☐ Blood in stool____________________	☐ Urethral dilation__________________
☐ Ear / hearing problems_____________	☐ Hemorrhoids______________________	☐ Gall bladder problems_______________	☐ Aching joints_____________________
☐ Dental problems__________________	☐ Tuberculosis______________________	☐ Liver problems____________________	☐ Pelvic / back injuries______________
☐ Thyroid problems_________________	☐ Asthma__________________________	☐ Hepatitis_________________________	☐ Seizures_________________________
☐ Rheumatic fever__________________	☐ Skin disorders____________________	☐ Diabetes_________________________	☐ Cancer__________________________
☐ Blood clotting problems_____________	☐ Stomach problems_________________	☐ Hypoglycemia_____________________	☐ Hospitalizations___________________
☐ Anemia__________________________	☐ Ulcers___________________________	☐ Bladder infection__________________	☐ Surgeries________________________
☐ Hemorrhage_______________________	☐ Chicken pox______________________	☐ Kidney infection___________________	☐ 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:
☐ High Blood Pressure_______________________	☐ Sexually transmitted diseases________________	☐ No. of pregnancies_________________________
☐ Cancer__________________________________	☐ Herpes ☐ Genital ☐ Oral	☐ No. of births_____________________________
☐ Diabetes_________________________________	☐ Severe emotional problems__________________	☐ Miscarriages______________________________
☐ Twins___________________________________	☐ Alcohol/Drug abuse _______________________	☐ Your weight at birth_________________________
☐ Severe emotional problems__________________	☐ Tobacco use______________________________	☐ Any complications__________________________
☐ Alcohol/Drug abuse_________________________	☐ Other___________________________________	____
☐ 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 your 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? Pre-pregnant weight__________

☐ Yes ☐ No Have you ever had anorexia, bulimia or other eating problems? Do you currently eat regular meals? ☐ Yes ☐ No

☐ Yes ☐ No Is there anything about the development of your sexuality that you'd like to discuss?

☐ Yes ☐ No Have you ever been I 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?