



Please complete the following for contact information and your baby's birth certificate data

Name: First Middle Last			Today's date	Phone (home / work / cell)
Race	Marital status	Occupation/Type of Business	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: Phone:	
Method of Payment: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid (Healthy Start) <input type="checkbox"/> Cash		How did you find out about us?		
Social Security Number			Husband's Social Security Number	

**PRESENT PREGNANCY**

Please answer the following questions to help us thoroughly review the health of you and your baby. This information is completely confidential.

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 (many of these are normal in pregnancy):

<input type="checkbox"/> Nausea _____	<input type="checkbox"/> Leg cramps _____	<input type="checkbox"/> Urinary complaints _____	<input type="checkbox"/> Work difficulties _____
<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 difficulties _____
<input type="checkbox"/> Infections _____	<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Vaginal discharge _____	_____
<input type="checkbox"/> Headache _____	<input type="checkbox"/> Constipation _____	<input type="checkbox"/> Hemorrhoids _____	<input type="checkbox"/> Other _____
<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 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 \_\_\_\_\_ Regular cycles?  Yes  No      Cycle length \_\_\_\_\_ # of days your period typically lasts \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_ Have you ever had an abnormal Pap? (dates) \_\_\_\_\_ 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

	Date	Birth / Miscarriage / Termination	# Weeks	Name	Sex	Weight	Hours Labor	Any Meds	Any 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 infections_____	<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 dependency_____	<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 dependency_____	<input type="checkbox"/> Other_____	_____
<input type="checkbox"/> Other_____	_____	_____

I am grateful for your sharing the following pregnancy-relevant information with me. It will be held in the strictest confidence.

- 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   Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?
- Yes    No   Have you ever been in an abusive relationship, including now (emotionally intimidated, hit, injured, or made to take part in sexual activities against your will)?
- Yes    No   Have you ever had severe emotional difficulties?
- Yes    No   Have you ever been on any medication for emotional or psychological difficulties?
- Yes    No   Is there anything about your relationships with yourself and/or others that you would like to discuss?

Please give brief directions to your home, including landmarks\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_