



Please complete the following contact information. Demographic details are required for your baby's birth certificate worksheet.

Name: First Middle Last			Today's date	Phone (home / work / cell)	
Race	Married? Y / N	School Grade/Educ. Level Completed	Occupation/Type of Work	Date of Birth	State of Birth
Address: Street City Zip County			Email		
Partner's Name: First Middle Last			Race	Date of Birth	State of Birth
Address (if different from above)		Phone (home / work / cell)		Occupation/Type of Work	
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"/> Cash <input type="checkbox"/> Medicaid (Title 19 or BadgerCare) Eligible for WIC? Y / N			How did you find out about us?		
Social Security Number		Medicaid/Forward Card Number	Husband's Social Security Number (if married)		

PRESENT PREGNANCY Do you have any allergies? _____

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

1st day of last menstrual period _____ How do you feel about this pregnancy? _____
 Normal? Yes No _____
 Planned pregnancy? Yes No _____ Partner's feelings? _____
 Suspected date of conception _____ Contraception used up to present: what/when/any problems? _____
 Pregnancy test (date) _____

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"/> Stress _____
<input type="checkbox"/> Vomiting _____	<input type="checkbox"/> Rash _____	<input type="checkbox"/> Abdominal / pelvic pain _____	<input type="checkbox"/> Work difficulties _____
<input type="checkbox"/> Fever _____	<input type="checkbox"/> Backache _____	<input type="checkbox"/> Vaginal bleeding / spotting _____	<input type="checkbox"/> Loneliness _____
<input type="checkbox"/> Infections _____	<input type="checkbox"/> Swelling _____	<input type="checkbox"/> Vaginal discharge _____	<input type="checkbox"/> Family/relationship difficulties _____
<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

What are your menstrual periods like for you and how long do they last? _____ Are your cycles regular? _____ Length of cycle? _____
 _____ Yes No _____
 When was your last Pap smear? _____ Have you ever had an abnormal Pap? (dates) _____ Cause & treatment for your abnormal pap? _____

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

<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"/> Thyroid Imbalance _____	<input type="checkbox"/> Herpes (Genital or Oral) _____	<input type="checkbox"/> No. of births _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Severe emotional problems _____	What is your own birth story? Did your mother (or sister) have any pregnancy/birth/postpartum/breastfeeding difficulties?
<input type="checkbox"/> Twins _____	<input type="checkbox"/> Alcohol/Drug dependency _____	_____
<input type="checkbox"/> Severe emotional problems _____	<input type="checkbox"/> Tobacco use _____	_____
<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 or 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 IV drugs, 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 HIV or AIDS?
- 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 any of your relationships that you would like to discuss?

Please give brief directions to your home, including landmarks _____

