

CLIENT REGISTRATION

Name _____

Address _____

City, State, Zip _____

Marital Status Married Single Divorced

Father/Partner _____

Your job: _____

Partner's job: _____

Financial problems? _____

Insurance Cash Pay

INSURANCE INFORMATION

Company: _____

Phone # _____

Policy # _____ Group # _____

I authorize the release of any medical or other information necessary to process this claim and accept my responsibility for fees not covered by my insurance company.

Insured's Name _____

(Signature): _____

GENERAL INFORMATION

How did you hear about us? _____

Planned Pregnancy? _____

Feelings about pregnancy? _____

Father's feelings about pregnancy? _____

What do you do to keep in shape physically?

If employed, please describe where you work, what you do, and how many hours you work:

Plans after the baby is born?

Are there any ethnic, cultural or religious preferences you would like to discuss?

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

Tobacco

Alcohol

Caffeine

Marijuana

Cocaine

Other Medications

Non-pres. drugs

Vitamins

Herbs

Fumes/sprays

Phone _____

Cell _____

Email _____

Mother's DOB _____

State of Birth _____

Mother's SS# _____

Father's DOB _____

State of Birth _____

Father's SS# _____

MENSTRUAL HISTORY

Last Menstrual Period _____

Conception? _____

Length of cycle? _____

Regular? _____

PRESENT PREGNANCY

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

Nausea

Vomiting

Poor appetite

Indigestion

Constipation

Hemorrhoids

Diarrhea

Abdominal/pelvic pain

Spotting/bleeding

Headaches

Dizziness

Blurred Vision

Swelling

Leg cramps

Backache

Urinary complaints

Colds, virus

Itching/rash

Varicose veins

Insomnia

Depression

Other

Measles/Viruses

Travel

Vaccinations

Cats

Ultrasounds

Name _____

FAMILY and MEDICAL HISTORY

Client
Family

Please indicate if you or your immediate family have ever had any of the following:

- High blood pressure
- Cancer
- Diabetes
- Heart disease
- Anemia
- Blood disorders
- Hepatitis/liver disease
- Kidney disease
- UTI
- Thyroid dysfunction
- Autoimmune disorder
- Neurological/Seizure disorder
- TB
- Uterine anomalies
- Hormone problems
- Severe emotional problems
- Alcohol/drug abuse

Client

- Severe headaches
- Vision/hearing problems
- Skin disorders
- Stomach problems
- Bowel problems/colitis
- Hemorrhoids
- Blood in stool
- Gall bladder problems
- Hypoglycemia
- Asthma
- Aching joints
- Pelvic/back injuries
- Major accidents
- Surgeries
- Hemorrhage/transfusion
- Varicose veins
- Other

Client
Father
Family

GENETIC SCREENING

Client over 35? Yes No

- Thalassemia
- Neural Tube defects
- Congenital Heart defects
- Down Syndrome
- Tay-Sachs
- Sickle Cell Disease/Trait
- Hemophilia
- Mental Defects/Autism

Client
Father
Family

- Congenital Anomalies
- Cerebral Palsy
- Muscular Dystrophy
- Cystic Fibrosis
- Cleft Lip/Palate
- History Miscarriages
- Twins
- Other

GYNECOLOGICAL HISTORY

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

Abnormal PAP smear consistent with malignancy or pre-malignancy? Explain: _____

- Yeast
- Trichomonas
- Group B Strep
- Bacterial vaginosis
- Chlamydia
- Gonorrhea
- Syphilis
- HIV or AIDS
- Genital Sores
- Herpes Genital Oral
- Condyloma (warts)
- Cervicitis
- Cervical surgery
- Cervical Polyp
- Ovarian cyst
- Fibroids
- PID/Pelvic Infection
- Endometriosis
- Abnormal bleeding
- Uterine surgery
- Breast lumps
- Breast surgery
- Infertility
- Other

ALLERGIES

Medications: _____

Environmental: _____

(Please list allergies) _____

FATHER OF THIS BABY

Health problems _____

- Severe emotional problems
- Alcohol/drug abuse
- Tobacco use

Sexually transmitted diseases:

What? _____

When? _____

Name _____

PREVIOUS PREGNANCY OUTCOMES Please record your own pregnancies, from earliest to most recent			
Date	# Weeks	Birth/Miscarriage/Termination	Comments/Problems

CONTRACEPTIVE HISTORY

Method	Dates	Comments/Problems

YOUR MOTHER'S HISTORY

No. of pregnancies _____ No. of births _____ How many born in hospital? _____ Born at home? _____
 What were your mother's labors like? _____
 Number of children she breastfed? _____ Your birth weight _____
 Does she support out-of-hospital birth? _____

QUESTIONNAIRE

- Yes No Have you or the FOB ever had hepatitis?
- 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 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 would 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 Has anyone ever told you, or do you think, you have ever used drugs or alcohol excessively?
- Yes No Have you ever been on any medications for psychological problems?

During the three months prior to conception and during this pregnancy, have you undergone any therapy or used drugs to treat a medical or emotional condition?

Please comment on any additional information I should be aware of concerning this pregnancy:



PRIOR PREGNANCIES

For each of your children, please provide the following information. Name _____

BORN (home/hosp./center)					
BIRTH DATE					
NAME					
GESTATION					
PREGNANCY PROBLEMS (glucose, protein, anemia, spotting, vaginal infections, continued nausea, high BP, pre-eclampsia, varicosities, excessive weight gain)					
FIRST LABOR SIGN					
WATER BROKE WHEN?					
LENGTH OF EARLY LABOR					
LENGTH OF ACTIVE LABOR					
LENGTH 2 ND STAGE					
PLACENTA					
EPISIOTOMY / TEAR					
PITOCIN INDUCTION? (check if yes, explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPIDURAL? (check if yes, explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FORCEPS / VACUUM					
CESAREAN? (check if yes, explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FETAL MONITOR					
BABY'S PRESENTATION					
APGAR					
WEIGHT					
BREASTFED					
NEWBORN with GBS?					
Rh neg? RhoGam?					
COMPLICATIONS MOTHER: (hemorrhage, toxemia, prolonged ROM, PP infection, PP depression) BABY: (distress, meconium, resuscitation, abnormalities, jaundice, problems 1 ST two weeks, death)					