Client Registration

Name First	Middle		Last		Maiden?	Date	Phone (home) (work)	
Race	Religion	Yrs Educ	Marital Status	Occupation/Type of Business		Date of Birth	State of Birth	
Address: Street			City		Zip	Inside City Limits? ☐ Yes ☐ No	How long at this address?	
Father of Baby: First	Middle		Last	Race	Yrs. Educ	Date of Birth	State of Birth	
Address (if different from above)						Phone(work) (home)	Occupation/type of business	
Partner/Husband (if different from Father)			Another person to contact in emergency Name:			relationship:	Phone:	
Method of Payment: ☐ Medicaid	☐ Other : ☐ Cash		Insurance Information: Copay Policy #			Name of Policy Holder: Group #		
Social Security Number	Father's SSN		SSN Requested for baby ☐ Yes ☐ No		Referred by:			

Please answer the following questions which will help determine if there are potential problems which should be discussed further. This information is completely confidential.

FAMILY HISTORY – *Indicate if anyone in your immediate family has ever had any of these, who; when.*

- ☐ High Blood Pressure_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Twins_____
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Other_____

FATHER OF BABY – *Indicate if the baby's father has ever had of these; when.*

- ☐ Sexually transmitted diseases_____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Tobacco use_____
- ☐ Other_____

YOUR MOTHER'S HISTORY – ***Please answer the following regarding your mother:***

- ☐ No. of pregnancies_____
- ☐ No. of births_____
- ☐ Miscarriages_____
- ☐ Any complications_____
- ☐ Your weight at birth_____
- ~~☐ Did she take DES with you?~~
  - ~~☐ Yes ☐ No~~

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

Date	#Weeks	Birth/Miscarriage/Termination	Comments/Problems

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 members 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? (circle)
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?

NAME _____

MEDICAL HISTORY Please indicate if you have ever had any of these; when:

- ☐ Severe headaches_____
- ☐ Eye/vision problems_____
- ☐ Ear/hearing problems_____
- ☐ Dental problems_____
- ☐ Thyroid problems_____
- ☐ Rheumatic fever_____
- ☐ Blood clotting problems_____
- ☐ Anemia_____
- ☐ Hemorrhage_____
- ☐ High blood pressure_____
- ☐ Varicose veins_____
- ☐ Hemorrhoids_____
- ☐ Tuberculosis_____
- ☐ Asthma_____
- ☐ Skin disorders_____
- ☐ Stomach problems_____
- ☐ Ulcers_____
- ☐ Chicken Pox_____
- ☐ Bowel problems/colitis_____
- ☐ Blood in stool_____
- ☐ Gall bladder problems_____
- ☐ Liver problems_____
- ☐ Hepatitis_____
- ☐ Diabetes_____
- ☐ Hypoglycemia_____
- ☐ Bladder infection_____
- ☐ Kidney infection_____
- ☐ Urinary surgery_____
- ☐ Urethral dilation_____
- ☐ Aching joints_____
- ☐ Pelvic/back injuries_____
- ☐ Seizures_____
- ☐ Cancer_____
- ☐ Hospitalizations_____
- ☐ Surgeries_____
- ☐ Other_____

Do you have any allergies? ☐ Yes ☐ No

Please list:_____

_____

GYNECOLOGIC HISTORY

Age at first period_____

Cycle length (days)_____

Regular? ☐ Yes ☐ No

Duration_____

When was your last Pap smear?

_____

Have you ever had an abnormal Pap? (dates)_____

Please describe_____

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

- ☐ Yeast_____
- ☐ Trichomonas_____
- ☐ Group B Strep_____
- ☐ Bacterial vaginosis_____
- ☐ Chlamydia_____
- ☐ Gonorrhea_____
- ☐ Syphilis_____
- ☐ PID/Pelvic infection_____
- ☐ Genital Sores_____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Condyloma (warts)_____
- ☐ Cervicitis_____
- ☐ Cervical surgery_____
- ☐ Cervical polyp_____
- ☐ Ovarian cyst_____
- ☐ Fibroids_____
- ☐ Endometriosis_____
- ☐ Abnormal bleeding_____
- ☐ Uterine surgery_____
- ☐ Breast lump(s)_____
- ☐ Breast surgery_____
- ☐ Infertility_____
- ☐ Other_____

Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you'd like to discuss?

_____

_____

_____

_____

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? ☐ Yes ☐ No

Suspected date of conception_____

Pregnancy test (date)_____

Planned pregnancy? ☐ Yes ☐ No

Feelings about pregnancy_____

Father's/Partner's feelings_____

Most recent birth control used_____

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

_____

_____

Please indicate if you've had any of the following problems during this pregnancy:

- ☐ Nausea_____
- ☐ Vomiting_____
- ☐ Fever_____
- ☐ Infections_____
- ☐ Headache_____
- ☐ Dizziness_____
- ☐ Indigestion_____
- ☐ Leg cramps_____
- ☐ Rash_____
- ☐ Backache_____
- ☐ Swelling_____
- ☐ Constipation_____
- ☐ Diarrhea_____
- ☐ Urinary complaints_____
- ☐ Abdominal/pelvic pain_____
- ☐ Vaginal bleeding/spotting_____
- ☐ Vaginal discharge_____
- ☐ Bleeding gums_____
- ☐ Varicose veins_____
- ☐ Hemorrhoids_____
- ☐ Depression_____
- ☐ Loneliness_____
- ☐ Family/relationship problems
- ☐ Work problems_____
- ☐ Other_____

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

- ☐ Tobacco_____
- ☐ Alcohol_____
- ☐ Caffeine_____
- ☐ Marijuana_____
- ☐ Cocaine_____
- ☐ Street drugs_____
- ☐ Other meds_____
- ☐ Non-pres. drugs_____
- ☐ Vitamins_____
- ☐ Herbs_____
- ☐ Fumes/sprays_____
- ☐ X-rays_____
- ☐ Ultrasound_____
- ☐ Measles/Viruses_____
- ☐ Travel_____
- ☐ Vaccinations_____
- ☐ Cats_____
- ☐ Other_____

Planned place of birth:

☐ Home ☐ Birth Center ☐ Hospital

If home, please indicate if you have:

☐ Water ☐ Electricity ☐ Telephone

Please use this space to add any other information regarding any of the above:

_____

_____

_____