

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			Name:			Another person to contact in emergency relationship: Phone:	
Method of Payment:		<input type="checkbox"/> Other :		Insurance Information: Copay _____		Name of Policy Holder: _____	
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Cash		Policy # _____		Group # _____	
Social Security Number		Father's SSN		SSN Requested for baby <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>Please complete this table regarding your own pregnancies (from earliest to most recent)</i>			
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:

- | | |
|--|---|
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Bowel problems/colitis |
| <input type="checkbox"/> Eye/vision problems | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Ear/hearing problems | <input type="checkbox"/> Gall bladder problems |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary surgery |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Urethral dilation |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Aching joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pelvic/back injuries |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other |

Do you have any allergies? Yes No

Please list: _____

GYNECOLOGIC HISTORY

Age at first period _____ When was your last Pap smear? _____
Cycle length (days) _____
Regular? Yes No Have you ever had an abnormal Pap? (dates) _____
Duration _____ Please describe _____

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

- | | |
|---|--|
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Cervicitis |
| <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Cervical surgery |
| <input type="checkbox"/> Group B Strep | <input type="checkbox"/> Cervical polyp |
| <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Ovarian cyst |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> PID/Pelvic infection | <input type="checkbox"/> Uterine surgery |
| <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Breast lump(s) |
| <input type="checkbox"/> Herpes: <input type="checkbox"/> Genital | <input type="checkbox"/> Breast surgery |
| <input type="checkbox"/> <input type="checkbox"/> Oral | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Condyloma (warts) | <input type="checkbox"/> 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:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Urinary complaints |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal/pelvic pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Vaginal bleeding/spotting |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Family/relationship problems |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diarrhea | |

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

- | | |
|--|--|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Herbs |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Fumes/sprays |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Measles/Viruses |
| <input type="checkbox"/> Street drugs | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Other meds | <input type="checkbox"/> Vaccinations |
| <input type="checkbox"/> Non-pres. drugs | <input type="checkbox"/> Cats |
| <input type="checkbox"/> Vitamins | <input type="checkbox"/> 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:

