Reviewed:_____ Date:_____

CLIENT REGISTRATION (please print) – (this info is used to fill out the birth certificate)

Legal name: First Middle Last Maiden	Phone: (Home) (Work) Email:	Date
Mother of baby: Race Religion Yrs Educ SS# Date of Birth	Occupation & Type of Business	State of birth
Father of Baby: Race Religion Yrs Educ SS# Date of Birth	Occupation & Type of Business	State of birth
Address: Street City Zip	Inside city limits? ☐ Yes ☐ No If no, give precinct number:	County
Referred by: Method of payment: ☐ Cash ☐ Insurance ☐ Medicaid	Another contact person in emergency: Name: Phone:	Relationship:
Primary support person: Relationship:	Want baby's immunization to be included in statewide immunization registry? ☐ Yes ☐ No	Want a SS# for baby? ☐ Yes ☐ No
Father of baby's address: Street (if different than above) City Zip	Phone: (Home) (Work) Email:	Your legal martial status:

FAMILY HISTORY – Indicate immediate family members & when

☐High Blood pressure_____
☐Cancer_____
☐Diabetes_____
☐Twins_____
☐Emotional problems_____
☐Alcohol/drug abuse_____
☐Tobacco use_____
☐Congenital malformations_____
☐Other_____

FATHER OF BABY – Indicate if the baby's father ever had any of these & when

☐Sexually transmitted diseases_____
☐Urethritis_____
☐Herpes: ☐ Genital ☐ Oral; when_____
☐Twins_____
☐Emotional problems_____
☐Alcohol/drug abuse_____
☐Tobacco use_____
☐Congenital malformations_____
☐ Other_____

YOUR MOTHER'S HISTORY: Complete the best you can

# of pregnancies_____
# of live births_____
Miscarriages_____
C-sections_____
Any complications_____
Your birth weight_____
Average birth weights_____
Did she take DES while pregnant with you? ☐ yes ☐ no ☐ not sure

PREVIOUS PREGNANCIES–Please complete regarding your own pregnancies: (use the back for more room if needed)

Date	# weeks	Birth/Miscarriage/Termination	Vaginal/meds/home/hospital	Comments/problems

QUESTIONNAIRE – Please answer the following questions, which will help determine if there are potential problems which should be discussed further. If any answers are yes, please give details on the back of this form.

☐ 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 Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
☐ Yes ☐ No Are you and the FOB related by blood? (i.e. cousins)
☐ Yes ☐ No Are you or the FOB from any of these ethnic/racial groups? (circle if appropriate)
Jewish Black/African Hispanic Asian Mediterranean Eskimo Haitian
☐ Yes ☐ No Have you or the FOB ever had hepatitis or jaundice?
☐ Yes ☐ No Have you or the FOB ever used any drug intravenously, had a blood transfusion, or bisexual relations?
☐ Yes ☐ No Have you or the FOB ever had a sexual partner who used IV drugs, had blood transfusion, or had bisexual relations?
☐ Yes ☐ No Have you or the FOB had more than five sexual partners in the past five years?
☐ Yes ☐ No Do you think you are at increased risk for HIV/AIDS?
☐ Yes ☐ No Have you ever experienced dramatic fluctuations in your weight?
☐ Yes ☐ No Have you ever had anorexia, bulimia, or eating problems?
☐ Yes ☐ No Have you ever been in an abusive relationship including now or been abused in the past? Including physically, emotionally, intimidated, beaten, injured, or made to take part in sexual activities against your will.
☐ Yes ☐ No Have you or the FOB ever had severe emotional problems?
☐ Yes ☐ No Have you or the FOB ever been treated or on any medications for psychological problems now or in the past?
☐ Yes ☐ No Has anyone ever told you or the FOB, or do you think, you have ever used alcohol or drugs excessively?

Reviewed:_____ Date:_____

NAME:_____ DATE:_____

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_____
- ☐ Allergies_____
- ☐ Stomach problems_____
- ☐ Ulcers_____
- ☐ Bowel problems_____
- ☐ Colitis_____
- ☐ Blood in stool_____
- ☐ Gallbladder problems_____
- ☐ Liver problems_____
- ☐ Hepatitis_____
- ☐ Diabetes_____
- ☐ Hypoglycemia_____
- ☐ Bladder infection_____
- ☐ Kidney infection_____
- ☐ Urinary surgery_____
- ☐ Urethral dilation_____
- ☐ Aching joints_____
- ☐ Pelvic/back injuries_____
- ☐ Seizures_____
- ☐ Hospitalizations_____
- ☐ Surgeries_____
- ☐ Other_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If so, please list:_____

GYNECOLOGICAL HISTORY:

Age at 1st period_____ When was your last Pap smear?_____

Cycle length (days)_____ Ever had an abnormal Pap?_____

Regular? ☐ Yes ☐ No If so, when?_____

Duration_____ If so, what?_____

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

- ☐ Yeast _____
- ☐ Trichomonas_____
- ☐ Gardnerella_____
- ☐ Bacterial vaginosis_____
- ☐ Chlamydia_____
- ☐ Gonorrhea_____
- ☐ Syphilis_____
- ☐ PID_____
- ☐ Genital sores_____
- ☐ Herpes: ☐ genital ☐ oral
- ☐ Condyloma (warts)_____
- ☐ Other_____
- ☐ Cervicitis_____
- ☐ Cervical surgery_____
- ☐ Cervical polyp_____
- ☐ Ovarian cyst_____
- ☐ Fibroids_____
- ☐ Endometriosis_____
- ☐ Abnormal bleeding_____
- ☐ Uterine surgery_____
- ☐ Breast lump(s)_____
- ☐ Breast surgery_____
- ☐ Infertility_____

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

Last normal menstrual period_____

Suspected date of conception_____

Pregnancy test (date)_____ Planned pregnancy?☐ Yes ☐ No

Feelings about pregnancy_____

Father's feelings_____

Most recent birth control used_____

Contraception used in past: what, when, any problems?_____

_____

Please indicate if you have had any of the following during this current pregnancy:

- ☐ Nausea_____
- ☐ Vomiting_____
- ☐ Fever_____
- ☐ 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_____
- ☐ Loneliness_____
- ☐ Depression_____
- ☐ Family problems_____
- ☐ Work problems_____
- ☐ Other_____

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

- ☐ Tobacco_____
- ☐ Alcohol_____
- ☐ Caffeine_____
- ☐ Marijuana_____
- ☐ Cocaine_____
- ☐ Street drugs_____
- ☐ Prescription drugs_____
- ☐ Non-pres drugs_____
- ☐ Vitamins_____
- ☐ Herbs_____
- ☐ Fumes/sprays_____
- ☐ X-rays_____
- ☐ Ultrasound_____
- ☐ Measles_____
- ☐ Viruses_____
- ☐ Vaccinations_____
- ☐ Cats_____
- ☐ Other_____

Planned place of birth:

☐ Home ☐ Birth Center ☐ Hospital

If home, please indicate if you have:

☐ Electricity ☐ Water ☐ Telephone

Please use this space to add any other information regarding any of the above or from the front page:

_____
_____
_____
_____
_____
_____
_____
_____