Patient's Name: Your height: Your Weight BEFORE pregnancy:
Age: Date of Birth:
Today's date: Who is your primary care doctor?:
What other doctors do you see?:

How were you referred to our clinic/doctor?:
What is the main problem or reason for seeing the doctor today?:

What pharmacy location do you prefer to have your prescriptions sent to(name/address):

Please list all current medications including name, strength, how often you take it, etc.
Include PRESCRIPTIONS and Over-the-counter medications.

Please list any medical problems YOU have or have had in the past.

Please list any surgeries you have had including the year surgery was performed.

Family History: please indicate if your family members are alive or deceased and list any medical problems for each.
(if you do not know family history details check here:_____)

	living?	medical problems
mother		
father		
other:		
other:		
other:		
other:		
other:		
other:		

Are you sexually active?

What is your usual method of pregnancy prevention/birth control?

Sexual preference (male,female,or both):

Do you drink alcohol?
what kind:
how much:

Tobacco
Please indicate below if you smoke now or in the past, and if so how much you smoke and what kind of tobacco you smoke, or if you quit when you last smoked.

Employment
Do you currently work or go to school:
Job title:
employer or school:

Baby's father's name: relationship (spouse or boyfriend)?:
How many children do you have?:
How many years of school have you finished?:
Preferred language:
Ethnicity:
Race:

Pregnancy History (please provide details requested below for ALL prior pregnancies including miscarriages or elective abortions)

DATE	WEEKS PREG	TYPE OF DELIVERY	Baby's Sex	Baby's weight	Complications during pregnancy or deliverey	Epidural?
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO
						YES/NO

Drug use information
Do you currently use drugs of any kind?:
Have you in the past used drugs of any kind?:
If you answered yes to either of the above please describe what drugs used and history of use, treatment, etc.:

Do you or the father of the baby have history of any of the following (please circle yes or no)

thalassemia	yes	no
open nural tube defect	yes	no

congenital heart defect	yes	no
down syndrome	yes	no
tay-sachs disease	yes	no
canavan disease	yes	no
familial dysautonomia	yes	no
cystic fibrosis	yes	no
huntington's chorea	yes	no
mental retardation	yes	no
autism	yes	no
fragile x disorder	yes	no
multiple sclerosis	yes	no
turner's syndrome	yes	no

Other disorder (please specify):

Current pregnancy

Are you currently having any pregnancy problems?

What date did your LAST period START?:

date:

How certain are you of the date?

ALLERGIES

Please list any medication, food, or other allergy. Please indicate what happens if you take the substance and if the reaction is mild or severe.