

Patient Information & Pregnancy Questionnaire

Name (First): _____ (Last): _____

Date of Birth (M/D/Y): _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ County (CA only): _____

Contact Info: Home #: _____ Cell: _____ Work: _____

PARTNER INFORMATION (if the patient is pregnant, then “partner” is the father of the pregnancy)

Name (First): _____ (Last): _____

Date of Birth (M/D/Y): _____ Occupation: _____

REFERRING PHYSICIAN INFORMATION:

Name: _____ Phone #: _____

Address: _____ City: _____

PREGNANCY AND EXPOSURE INFORMATION

Are you currently pregnant? NO YES **Due date:** _____

Have you taken any medications during this pregnancy (besides prenatal vitamins or Tylenol)? NO YES

If yes, please list:

Since becoming pregnant, have you had any:

(or if not pregnant please check current exposures)

Recreational Drugs NO YES _____

Cigarettes NO YES _____

Alcohol NO YES _____

Fevers NO YES _____

X-rays NO YES _____

Do you have any of the following conditions?

Diabetes? NO YES _____

A seizure disorder? NO YES _____

CONFIDENTIAL or PRIVATE MESSAGES:

Integrated Genetics/Esoterix Genetic Laboratories, LLC has my permission to leave detailed messages about **confidential medical information and test results** at the number(s) noted below. YES NO (if no, proceed to the signature box)

Preferred confidential phone number: Home Cell Work Other: _____

Who else can we leave test results with? _____ Phone: _____

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: _____ DATE: _____