Patient Information & Pregnancy Questionnaire

Last Name: ______________________ First Name: ____________________ Date of Birth (M/D/Y): _________________

Address: ____ City: ______________________________

State: _______ Zip: ____________ County (CA only): _________________ Occupation: _________________________

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

Last Name: _________________________________ First Name: ____

Date of Birth (M/D/Y): _________________________ Occupation: ____

PATIENT CONTACT INFORMATION AND AUTHORIZATION:

Cell: _________________________ Home: __________________________ Work: _____________________________

May we leave detailed voice messages that may include **confidential medical information and test results**? ☐NO ☐YES

If yes, please provide a confidential phone number: ____

●Patient has the right to revoke permission for the confidential voice mail ●Patient assumes responsibility for information left on the confidential voice mail

Can we leave test results with anyone else? ☐NO ☐YES If yes, please provide information below:

Name: _______________________ Phone: __________________________ Relationship to Patient: _______________

REFERRING DOCTOR OR CLINIC 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 (greater than 101˚ F) ☐NO ☐YES _______________

X-rays (other than dental) ☐NO ☐YES _______________

Do you have any of the following conditions?

Diabetes? ☐NO ☐YES

A seizure disorder? ☐NO ☐YES

Lupus? ☐NO ☐YES

Are you adopted? ☐NO ☐YES

Is your partner adopted? ☐NO ☐YES

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

PATIENT SIGNATURE: ____________________________________ **DATE:** ______________________________

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