PATIENT 'S INFORMATION

Name (Last):___________________________________ (First): ________________________________

Date of Birth / Age:_____________________________ Occupation: _________________________

Race / Ethnicity:____________________________

FATHER OF THE BABY'S INFORMATION

Name (Last):___________________________________ (First): ________________________________

Date of Birth / Age:_____________________________ Occupation: _________________________

Race / Ethnicity:____________________________

Are you and the father of the baby related by blood (i.e. – cousins)? YES NO

Is the father of this baby your partner? YES NO

PHARMACY INFORMATION

Pharmacy Name/Location:______________________________________ City/State/Zip:________________

Please list any medications you take on a regular basis: ____
If pregnant, please list any other **MEDICATIONS**, **DOSAGE**, and your **GESTATIONAL AGE** when you were taking the medication during your pregnancy (other than prenatal vitamins), if known:

____

____

____

Since becoming pregnant, have you had any:

			If "YES", please explain:
Recreational Drugs	YES	NO	____
Cigarettes	YES	NO	____
Alcohol	YES	NO	____
Fevers (< 6w gestation, >100° F)	YES	NO	____
X-rays **(NOT DENTAL)**	YES	NO	____

CONTACT INFORMATION / PHONE NUMBERS

Patient Home/Cell:___________________ Work:_______________________

Who else can we leave test results with?:___________________Phone:____________________________

May we leave **CONFIDENTIAL MESSAGES** on the voicemail of the numbers listed above? YES NO

I HAVE ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE:__________________________________DATE: ________________________