

PATIENT INFORMATION & PREGNANCY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y): _____ Age: _____

Address: _____ City: _____

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

PARTNER INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y): _____ Age: _____

Occupation: _____ Is your partner the biological father of the pregnancy? NO YES

If no, did you use a sperm donor? NO YES

PATIENT CONTACT INFORMATION AND AUTHORIZATION

Cell: _____ Home: _____ Work: _____

May we leave a detailed voice message that includes **confidential medical information and test results**? YES NO

If YES, check all that apply: Cell Home Work

If we are unable to reach you, is there another person with whom we can leave a detailed voice message that includes **confidential medical information and test results**: NO YES If YES, complete below:

Name: _____ Relationship: _____ Number: _____

•Patient has the right to revoke permission for the confidential voice mail

•Patient assumes responsibility for information left on the confidential voice mail

REFERRING DOCTOR (PRIMARY OB/GYN) OR CLINIC INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

PREGNANCY AND EXPOSURE INFORMATION

Do you have or have you ever had any of the following?

Diabetes? NO YES

Seizure disorder? NO YES

Lupus? NO YES

Graves' disease or Hashimoto

Thyroiditis or thyroid cancer? NO YES

Are you currently pregnant? NO YES

Due date: _____

Are you or the biological father of the pregnancy adopted?

NO YES If yes, please specify: _____

Do you take any medications on a regular basis? NO YES

If yes, please specify. If you are pregnant, please list any medications you have taken since conception (other than prenatal vitamins and Tylenol): _____

Since becoming pregnant, have you had any:

Cigarettes NO YES _____

Alcohol NO YES _____

Recreational Drugs NO YES _____

Fevers (greater than 101° F) NO YES _____

X-rays (other than dental) NO YES _____

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

PATIENT SIGNATURE: _____ DATE: _____