# Client Information Form

*Please complete this form in preparation for your initial visit. The information is required for completion of your baby's birth certificate and will be kept confidential.*

| | | | | |
|---|---|---|---|---|
| First Middle Last (Maiden)<br>Name: | | | Employer: | |
| Address: | | | Emp. Address: | State: Zip: |
| City: | State: | Zip: | Emp. Phone: | Position: |
| Phone #: | E-mail address: | | How long at present Employer? | Do you have insurance?<br>Yes ❒ No ❒ |
| Marital Status: M S D (Please circle) | | | Insurance Co.: | |
| Birth Date: | Birthplace:<br>(State or foreign country) | | Ins. Address: | |
| Education (highest grade completed): | | | Ins. Phone: | State: |
| Social Security Number: | | | Policy or Group #: | |
| Drivers License #: | | | Subscriber ID #: | |
| Medicaid # (if applicable): | | | | |

**Father's Name**:

| | | | |
|---|---|---|---|
| Birth Date: | Birthplace:<br>(state or foreign country) | How long at present Employer? | |
| Education: (highest grade completed) | | Do you have Insurance? Yes ❒ No ❒ | |
| Driver's License #: | | Insurance Co.: | |
| Social Security Number: | | Ins. Address: | |
| Employer: | | Ins. Phone: | |
| Employer Address: | | Policy or Group #: | |
| Phone: | Position: | Subscriber ID #: | |

Person financially responsible for this account:

If you do not have insurance, how do you intend to pay? Cash - Check - Credit Card -

| | | |
|---|---|---|
| Physician's Name: | Address: | Phone: |
| Any religious preference you would like me to know about? | | |
| Nearest relative not residing with you: | | Phone: |
| Whom may I thank for referring you? | | Phone: |
| In case of emergency please contact: | | Phone: |

Signature: _____ Date:_____

# Client Registration (please print)

Please complete this form in preparation for your Initial visit. Your responses will be kept completely confidential. In the event your records are copied for another care provider, this page will not be copied. If you need more space, please use the area provided at the end. Thank you.

**YOUR FAMILY HISTORY --** *Indicate if anyone in your immediate family has ever had any of these; who; when.*

❑ High blood pressure _____
❑ Cancer _____
❑ Diabetes _____
❑ Twins _____
❑ Severe emotional problems _____
❑ Alcohol/drug abuse _____
❑ Other _____

**FATHER OF BABY --** *Indicate if the baby's father has ever had any of these; when.*

❑ Sexually transmitted diseases _____
❑Urethritis _____
❑ Herpes: ❑ genital; ❑ oral _____
❑ Severe emotional problems _____
❑ Alcohol/drug abuse _____
❑ Tobacco use _____
❑ Other _____

**YOUR MOTHER'S HISTORY --** *Please answer the following regarding your mother.*

No. of pregnancies _____
No. of live births _____
Miscarriages _____
Any complications _____
Your weight at birth _____
Did she take DES while pregnant with you?
❑ Yes ❑ No

**PREVIOUS PREGNANCY OUTCOMES** *Please complete this table regarding your own pregnancies (from earliest to most recent):*

| Date: | # weeks | Birth/Miscarriage/Termination | Comments/Problems | Sex | Weight | Name |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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**QUESTIONNAIRE**

*Please answer the following questions which will help determine if there are potential problems which should be discussed further. Again, this information is completely confidential.*

Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?
Yes No Are you or the FOB related by blood? (e.g. cousins)
Yes No Are you or the FOB from any of these ethic/racial groups? (circle)
Jewish Black/African Asian Mediterranean Eskimo Haitian
Yes No Have you or the FOB ever had hepatitis or jaundice?
Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?
Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
Yes No Have you had more than five sexual partners in the past five years?
Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
Yes No Do you think you are at increased risk for hepatitis?
Yes No Do you think you are at increased risk for AIDS/HIV?
Yes No Have you ever experienced dramatic fluctuations in your weight?
Yes No Have you ever had anorexia, bulimia or eating problems?
Yes No Is there anything about the development of your sexuality that you would like to discuss?
Yes No Do you feel a need to discuss with me privately any history of an abusive relationship, including now, or some past abuse (including physical abuse or emotional intimidation or having been beaten, injured or made to take part in sexual activities against your will)?
Yes No Have you ever had severe emotional problems?
Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

**NAME:**_____

***MEDICAL HISTORY*** *Please indicate if you have ever had any of these; when:*

- ❑ Severe headaches _____
- ❑ Eye/Vision problems _____
- ❑ Ear/hearing problems _____
- ❑ Dental problems _____
- ❑ Thyroid problems _____
- ❑ Rheumatic fever _____
- ❑ Blood clotting problems ____
- ❑ Anemia _____
- ❑ Hemorrhage _____
- ❑ High blood pressure _____
- ❑ Varicose veins _____
- ❑ Hemorrhoids _____
- ❑ Tuberculosis _____
- ❑ Asthma _____
- ❑ Allergies _____
- ❑ Stomach problems _____
- ❑ Ulcers _____
- ❑ Bowel problems _____
- ❑ Colitis _____
- ❑ Blood in stool _____
- ❑ Gall bladder problems _____
- ❑ Liver problems _____
- ❑ Hepatitis _____
- ❑ Diabetes _____
- ❑ Hypoglycemia _____
- ❑ Bladder infection _____
- ❑ Kidney infection _____
- ❑ Urinary surgery _____
- ❑ Urethral dilation _____
- ❑ Aching joints _____
- ❑ Pelvic/back injuries _____
- ❑ Seizures _____
- ❑ Hospitalizations _____
- ❑ Surgeries _____
- ❑ Other _____

Do you have any allergies to any medications? ❑ Yes ❑ No

***GYNECOLOGICAL HISTORY***

Age at 1st period? _____ When was your last Pap smear? _____

Cycle length (days) ____ Have you ever had an abnormal Pap?_____

Regular? ❑ Yes ❑ No If so, when?_____

Duration? _____ If so, what?_____

***Please Indicate*** *if you have ever had any of the following; when :*

- ❑ Yeast _____
- ❑ Trichomonas _____
- ❑ Gardnerella _____
- ❑ Bacterial vaginosis _____
- ❑ Chlamydia _____
- ❑ Gonorrhea _____
- ❑ Syphilis _____
- ❑ PID _____
- ❑ Genital sores _____
- ❑ Herpes: ❑ genital; ❑ oral
- ❑ Condyloma (warts) _____
- ❑ Other _____
- ❑ Cervicitis _____
- ❑ Cervical surgery _____
- ❑ Cervical polyp _____
- ❑ Ovarian cyst _____
- ❑ Fibroids _____
- ❑ Endometriosis _____
- ❑ Abnormal bleeding _____
- ❑ Uterine surgery _____
- ❑ Breast lump(s) _____
- ❑ Breast surgery _____
- ❑ Infertility _____

*Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you'd like to discuss?*

_____
_____
_____
_____
_____
_____
_____

_____

***PRESENT PREGNANCY***

Last menstrual period (1st day) _____ Normal? ❑ Yes ❑ No
Last normal menstrual period _____
Suspected date of conception _____
Pregnancy test (date) _____ Planned pregnancy? ❑ Yes ❑ No

Feelings about pregnancy _____

Father's feelings _____
Do you plan to breastfeed?
❑ Yes, experienced. ❑ Yes, no experience ❑ Undecided ❑ No

Most recent birth control used _____
Contraception used in past: what, when, any problems? _____
_____

***Please indicate*** *if you've had any of the following problems during this current pregnancy:*

- ❑ Nausea _____
- ❑ Vomiting _____
- ❑ Fever _____
- ❑ Headache _____
- ❑ Dizziness _____
- ❑ Indigestion _____
- ❑ Leg Cramps _____
- ❑ Rash _____
- ❑ Backache _____
- ❑ Swelling _____
- ❑ Constipation _____
- ❑ Diarrhea _____
- ❑ Other _____
- ❑ Urinary complaints _____
- ❑ Abdominal/pelvic pain _____
- ❑ Vaginal bleeding/spotting ___
- ❑ Vaginal discharge _____
- ❑ Bleeding _____
- ❑ Varicose veins _____
- ❑ Hemorrhoids _____
- ❑ Loneliness _____
- ❑ Depression _____
- ❑ Family/relationship problems _____
- ❑ Work problems _____

***Please indicate*** *if you have used or been exposed to any of the following during this pregnancy:*

- ❑ Tobacco _____
- ❑ Alcohol _____
- ❑ Caffeine _____
- ❑ Marijuana _____
- ❑ Cocaine _____
- ❑ Street drugs _____
- ❑ Prescription drugs _____
- ❑ Non-pres. Drugs _____
- ❑ vitamins _____
- ❑ Herbs _____
- ❑ Fumes/sprays _____
- ❑ X-rays _____
- ❑ Ultrasound _____
- ❑ Measles _____
- ❑ Viruses _____
- ❑ Vaccinations _____
- ❑ Cats _____
- ❑ Other _____

***Planned place of birth:***
❑ Home ❑ Hospital ❑ Other
*If home, please indicate if you have:*
❑ Electricity ❑ Water ❑ Telephone

***Please use this space to add any other information you wish to give:***

_____
_____
_____
_____
_____