

Reviewed: _____ Date: _____

CLIENT REGISTRATION (please print) – (this info is used to fill out the birth certificate)

Legal name: First	Middle	Last	Maiden	Phone: (Home) (Work) Email:	Date
Mother of baby: Race	Religion	Yrs Educ	SS#	Date of Birth	Occupation & Type of Business State of birth
Father of Baby: Race	Religion	Yrs Educ	SS#	Date of Birth	Occupation & Type of Business State of birth
Address: Street		City	Zip	Inside city limits? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give precinct number:	County
Referred by:	Method of payment: <input type="checkbox"/> Cash <input type="checkbox"/> Insurance <input type="checkbox"/> Medicaid			Another contact person in emergency: Name: Phone:	Relationship:
Primary support person:	Relationship:			Want baby's immunization to be included in statewide immunization registry? <input type="checkbox"/> Yes <input type="checkbox"/> No	Want a SS# for baby? <input type="checkbox"/> Yes <input type="checkbox"/> No
Father of baby's address: Street (if different than above)		City	Zip	Phone: (Home) (Work) Email:	Your legal martial status:

FAMILY HISTORY – Indicate immediate family members & when

- High Blood pressure _____
- Cancer _____
- Diabetes _____
- Twins _____
- Emotional problems _____
- Alcohol/drug abuse _____
- Tobacco use _____
- Congenital malformations _____
- Other _____

FATHER OF BABY – Indicate if the baby's father ever had any of these & when

- Sexually transmitted diseases _____
- Urethritis _____
- Herpes: Genital Oral; when _____
- Twins _____
- Emotional problems _____
- Alcohol/drug abuse _____
- Tobacco use _____
- Congenital malformations _____
- Other _____

YOUR MOTHER'S HISTORY:

- Complete the best you can
- # of pregnancies _____
 - # of live births _____
 - Miscarriages _____
 - C-sections _____
 - Any complications _____
 - Your birth weight _____
 - Average birth weights _____
 - Did she take DES while pregnant with you? yes no not sure

PREVIOUS PREGNANCIES – Please complete regarding your own pregnancies: (use the back for more room if needed)

Date	# weeks	Birth/Miscarriage/Termination	Vaginal/meds/home/hospital	Comments/problems

QUESTIONNAIRE – Please answer the following questions, which will help determine if there are potential problems which should be discussed further. If any answers are yes, please give details on the back of this form.

- 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 Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
- Yes No Are you and the FOB related by blood? (i.e. cousins)
- Yes No Are you or the FOB from any of these ethnic/racial groups? (circle if appropriate)
Jewish Black/African Hispanic Asian Mediterranean Eskimo Haitian
- Yes No Have you or the FOB ever had hepatitis or jaundice?
- Yes No Have you or the FOB ever used any drug intravenously, had a blood transfusion, or bisexual relations?
- Yes No Have you or the FOB ever had a sexual partner who used IV drugs, had blood transfusion, or had bisexual relations?
- Yes No Have you or the FOB had more than five sexual partners in the past five years?
- Yes No Do you think you are at increased risk for HIV/AIDS?
- Yes No Have you ever experienced dramatic fluctuations in your weight?
- Yes No Have you ever had anorexia, bulimia, or eating problems?
- Yes No Have you ever been in an abusive relationship including now or been abused in the past? Including physically, emotionally, intimidated, beaten, injured, or made to take part in sexual activities against your will.
- Yes No Have you or the FOB ever had severe emotional problems?
- Yes No Have you or the FOB ever been treated or on any medications for psychological problems now or in the past?
- Yes No Has anyone ever told you or the FOB, or do you think, you have ever used alcohol or drugs excessively?

NAME: _____

DATE: _____

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 _____
- Other _____
- Bowel problems _____
- Colitis _____
- Blood in stool _____
- Gallbladder problems _____
- Liver problems _____
- Hepatitis _____
- Diabetes _____
- Hypoglycemia _____
- Bladder infection _____
- Kidney infection _____
- Urinary surgery _____
- Urethral dilation _____
- Aching joints _____
- Pelvic/back injuries _____
- Seizures _____
- Hospitalizations _____
- Surgeries _____

Do you have any allergies to any medications? Yes No

If so, please list: _____

GYNECOLOGICAL HISTORY:

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

Cycle length (days) _____ 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 _____

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 _____

Most recent birth control used _____

Contraception used in past: what, when, any problems? _____

Please indicate if you have had any of the following during this current pregnancy:

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

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 Birth Center Hospital

If home, please indicate if you have:

Electricity Water Telephone

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

Please use this space to add any other information regarding any of the above or from the front page:
