



Thank you for choosing the Medford Women's Clinic for your obstetrical care. By following the suggested guidelines below, you will help us provide you with the best care and save you time at your appointment.

**Things to do before your appointment:**

- ✓ Fill out the enclosed information sheets. Remember to complete both sides. Answer all questions to the best of your ability.
- ✓ Contact your health plan insurance. In some cases, **obstetrical services are not covered by health insurance**. Please ask your health plan to see if they cover "obstetrical services."
- ✓ Please check with your Primary Care Provider to be sure a **referral** is sent to us prior to your appointment if one is needed.

**The day of your appointment:**

- ✓ Arrive **fifteen minutes** before your scheduled appointment.
- ✓ Have your insurance card and photo ID with you.
- ✓ Have your forms completed and here with you on your visit.
- ✓ Because the initial OB appointment can be up to two hours long, please arrive on time, and make arrangements for childcare. Feel free to bring your partner or spouse.
- ✓ If you are Private Pay, payment is due on the day of service.

If you are unable to keep this appointment, please give our office **at least** a twenty-four hour notice. Should you have any questions or need assistance in completing any of the forms, please contact our office. Thank you for selecting us to help you with your health care needs.



3170 State Street  
Medford, OR 97504-8450  
(541) 864-8900

# PATIENT REGISTRATION

TODAY'S DATE \_\_\_\_\_

## PATIENT

LEGAL NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
last, first, middle

ADDRESS: \_\_\_\_\_  
Street, P.O. Box city state zip

E-MAIL: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes \_\_\_\_\_ No \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

IF YES, UNDER WHAT NAME? \_\_\_\_\_

EMERGENCY CONTACT: NAME: \_\_\_\_\_ /RELATION \_\_\_\_\_ PHONE \_\_\_\_\_

## GUARANTOR (RESPONSIBLE PARTY if different from patient) OR CUSTODIAL PARENT

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
last, first, middle

ADDRESS (If different) \_\_\_\_\_  
Street, P.O. Box city state zip

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

## SPOUSE/PARENT/RELATIVE/CLOSE FRIEND (please circle one) (Different person from above, please)

NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
last, first, middle

ADDRESS (If different) \_\_\_\_\_  
Street, P.O. Box city state zip

## INSURANCE INFORMATION (Please check those which apply)

I HAVE: Medicare \_\_\_\_\_ Medicaid Card \_\_\_\_\_ Health Insurance \_\_\_\_\_ No insurance \_\_\_\_\_

MEDICARE: ID # \_\_\_\_\_

MEDICAID CARD. Present Card to Receptionist. **Oregon Health Plan?** Yes \_\_\_\_\_ No \_\_\_\_\_ Oregon Health Plan Type (As listed in right-hand column on card) \_\_\_\_\_

PRIMARY HEALTH INSURANCE: Company \_\_\_\_\_ ID/ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
PLEASE PRESENT CARD TO RECEPTIONIST

INSURED NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

SECOND HEALTH INSURANCE: Company \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
PLEASE PRESENT CARD TO RECEPTIONIST

INSURED NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

I am receiving medical treatment as a result of an accident: Yes \_\_\_\_\_ No \_\_\_\_\_ **(Please complete accident report form)**

If Yes, what type of accident? Motor Vehicle \_\_\_\_\_ Work Accident \_\_\_\_\_ Other \_\_\_\_\_

I authorize the medical treatment of this patient. \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent or Guardian

## ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents under 18, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

\_\_\_\_\_  
(patient signature) (date)

I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(authorized signature of subscriber) (name of ins. co.)

to pay and hereby assign Medford Women's Clinic, LLP all benefits, if any, otherwise payable to me for my physician's services.



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Medford, OR 97504-8450
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Med Rec #: \_\_\_\_\_
Name: \_\_\_\_\_
Birthdate: \_\_\_\_\_ Age \_\_\_\_\_
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_
PCP \_\_\_\_\_

Date \_\_\_\_\_ Referring physician \_\_\_\_\_

Occupation (past and present) \_\_\_\_\_

Reason for coming to the Clinic \_\_\_\_\_

Marital Status \_\_\_\_\_ Next of Kin \_\_\_\_\_ Phone # \_\_\_\_\_

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- Diabetes, Heart disease, High blood pressure, Cholesterol problem, Lung disease, Ulcers, Brain or nerve disease (stroke), Liver disease or hepatitis, Arthritis, Tuberculosis, Cancer, Blood clots or phlebitis, Depression/Anxiety, Kidney disease/stones, Acid reflux or hiatal hernia, Migraine, Environmental allergies, Seizures, Asthma, Tuberculosis or abnormal skin test, Osteoporosis, Thyroid disorder, Sexually transmitted disease, Other

Operations/Hospitalizations (includes tonsillectomy and apendectomy)

Table with 3 columns: Date, Operation/Hospitalization, Complications

Severe Accidents and Injuries

\_\_\_\_\_

Do you regularly wear a seat belt? No Yes Do you regularly wear a helmet when bicycling or motorcycling? No Yes

Allergies and Adverse Medication Reactions (please list reaction)

\_\_\_\_\_

Tobacco Use? No Yes Pkgs/day # years Quit? Year quit

Alcohol Use? No Yes Drinks/day Drinks/week Beer Wine Hard liquor

Have you ever felt you should cut down on your drinking? No Yes
Have you ever been annoyed by people criticizing your drinking? No Yes

Recreational drugs? No Yes IV drug test? No Yes Last HIV test?

Female Patients

Last menstrual period Last pap smear Last mammogram

Number of pregnancies Number of births Contraception

Irregular periods Abnormal pap smear Painful periods Heavy periods

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin - with dosage.

\_\_\_\_\_

Glasses milk/day? Last osteoporosis scan Calcium supplements (mg/day)?

Flu shot No Yes When How often do you exercise?
Tetanus booster No Yes When What is your workout?
Pneumonia vaccine No Yes When
Hepatitis B vaccine No Yes When Last lower GI or lower scope?

SEE REVERSE SIDE

## FAMILY HISTORY

	Age of death	Age if alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			
Significant Illness in Grandparents, Cousins, Aunts, Uncles or Children?			

Remember, most diseases that "run in the family" are *not* genetic, but rather reflect lifestyle or behavior patterns that we learn in our families.

	No	Yes
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>

**REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced).**

**General**

- Recent fever
- Weight loss
- Night sweats
- Loss of energy
- Change in lymph nodes
- Snoring
- Trouble sleeping

**Skin**

- Rashes
- Changes in mole

**Blood**

- Easy bruising
- Excessive bleeding
- Transfusions

**Ears**

- Ringing
- Deafness

**Eyes**

- Cataracts
- Blind spots
- Double vision
- Trouble seeing
- When was you last eye exam?  
by eye DR? \_\_\_\_\_

**Nose and Mouth**

- Nosebleeds
- Tooth pain
- Sore throat
- Sinus pain
- Nasal congestion

**Neck**

- Goiter
- Difficulty swallowing

**Breasts**

- Discharge from nipples
- Lumps

**Cardiovascular**

- Chest pain
- Shortness of breath
- Leg swelling
- Heart murmur
- Palpitations
- Varicose veins

**Pulmonary**

- Wheezing
- Cough
- Pain when you breathe
- Excessive sputum
- Cough up blood

**Digestive**

- Poor appetite
- Gas or heartburn
- Nausea
- Vomiting
- Vomiting blood
- Abdominal pain or cramping
- Constipation
- Diarrhea
- Hemorrhoids
- Hernia
- Jaundice
- Rectal bleeding

**Genitourinary**

- Burning on urination
- Bloody urine
- Incontinence
- Infections
- Difficulty urination
- Urination at night: # times
- Difficulty with erections
- Sexually transmitted diseases
- Multiple sexual partners

**Skeletal**

- Fractures
- Arthritis
- Leg pain when you walk
- Back or neck pain

**Brain and nerves**

- Convulsions
- Dizziness
- Blackouts
- Weakness
- Stroke
- Headaches
- Depression, low motivation
- Numbness
- Anxiety, excessive worry

Is there anyone that you're afraid of? \_\_\_\_\_

Source of stress? \_\_\_\_\_

Do you have an Advanced Directive for end-of-life? \_\_\_\_\_



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Med Rec #: _____
Last Name (Print): _____
First Name (Print): _____ MI _____
Birthdate: _____

**POLICY ON PATIENT ACCOUNTS AND CONDITIONS OF TREATMENT**

Medford Women’s Clinic is a private institution that operates for the benefit of the people who seek the services of our medical staff. We provide quality care, at what we believe to be fair and reasonable fees. Since we do not receive financial assistance from any outside source, we must recover the cost of providing services from our patients.

It is Medford Women’s Clinic policy that the responsibility for pre-authorization and paying for care will be placed on those who receive it. Therefore, all accounts will be administered under the following guidelines:

- 1. INSURANCE VERIFICATION / PRE-CERTIFICATION.** Many insurance companies require pre-authorization or a second opinion for some medical procedures. The responsibility is the patient’s to determine the procedure and guide the Medford Women’s Clinic in obtaining necessary pre-authorizations or second opinions when needed. Failure to obtain necessary pre-authorizations or second opinions may result in a reduction or rejection of benefits by the insurance company.
- 2. FIRST-TIME PATIENT.** Any first-time patient at Medford Women’s Clinic is required to pay for her visit on the day of service if she has not met her annual deductible or the visit is not covered by health insurance. The obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collections, the patient pays all expenses.
- 3. ACCOUNT BALANCE.** If you have a balance on your account you will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. We will bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Medford Women’s Clinic and you will be responsible for any deductible, co-payments, or other patient balances.
- 4. PAYMENT OPTIONS.** Payment options include cash, check, Visa, MasterCard, or Discover cards. If you have special financial needs, feel free to discuss this with our Patient Accounts Department to establish an extension of credit terms. Interest accrues on changes not paid after 90 days of the first bill at a rate of 1% per month ( 12% a year) until paid in full.
- 5. MEDICARE PATIENTS.** Medford Women’s Clinic is a participating provider with Medicare. Medicare will pay 80% of what they allow, minus your \$100.00 annual deductible if this has not been met. You will be responsible for the \$100.00 deductible and 20% through supplemental insurance or patient payment. Also, by signing this sheet, it will authorize any holder of medical or other information regarding the patient named above to release such information to the Social Security Administration or to its intermediate or carriers effective from this date.
- 6. HOSPITAL AND OTHER OUTSIDE CHARGES.** Hospital bills are separate from those of the providers at the Medford Women’s Clinic. Services provided by the hospital will be billed from there. It is also sometimes necessary to send some laboratory / pathology specimens to special laboratories. If this is necessary, you may receive billing for those services from a laboratory other than the Medford Women’s Clinic. Questions arising from bills from these outside services must be directed to the providers of those services.
- 7. AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR PURPOSE OF SERVICE REIMBURSEMENT.** I hereby authorize Medford Women’s Clinic to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient’s medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Medford Women’s Clinic from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Medford Women’s Clinic has already taken action on my claim.
- 8. OTHER OPTIONS.** I would like to be informed of any clinical studies that may enhance my medical treatment. I authorize my medical information, securely and confidentially, transferred to the Advanced Clinical Research department affiliated with the Medford Women’s Clinic.

Occasionally we may wish to contact you. Please let us know your wishes as to how you would like to authorize receiving information from us. This information will most likely be test results, or answers to your questions.

- Email, specify email address: \_\_\_\_\_
- Phone, specify preferred number: \_\_\_\_\_
- Via message left on answering machine or voice mail
- US Mail system
- All of the above

Please send me special offers or women’s health updates via email.

## OBSTETRICAL DATABASE

### GENERAL INFORMATION

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work/Other Phone Number: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Referred By: \_\_\_\_\_

Religion: \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed  Other: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Partner Occupation: \_\_\_\_\_

Education Level: 10 11 12 College 1 2 3 4 4+ Other: \_\_\_\_\_

Hobbies: \_\_\_\_\_

### GYN HISTORY

Age at onset of menstruation: \_\_\_\_\_

Number of days between typical period: \_\_\_\_\_

Are you menstrual periods usually regular? Yes  No  If no, please explain: \_\_\_\_\_

Date of your last menstrual period? \_\_\_\_\_

What form of contraception have you used in the past? Birth Control Pills, IUD,  
Diaphragm, DepoProvera, Norplant, Rhythm Method, Condoms or Abstinence.

Have you ever been treated for any sexually-transmitted diseases? Chylamydia,  
Gonorrhea or Herpes? \_\_\_\_\_

Have you ever had an IUD? If yes, date removed?: \_\_\_\_\_

Have you ever had an abnormal pap? If yes, please explain: \_\_\_\_\_

Have you ever had any surgery on your female organs? If yes, please explain and give dates: \_\_\_\_\_

Did your mother take DES when she was pregnant with you? Yes  No

When was the first day of your last period?: \_\_\_\_\_

Is this a planned pregnancy?: Yes  No

How tall are you?: \_\_\_\_\_

What is your partner's weight and height?: \_\_\_\_\_

Is this your partner's first baby?: \_\_\_\_\_

Have you had a problem with infertility in the past?: Yes  No  If yes, please explain: \_\_\_\_\_

Have you taken any drugs for fertility in this pregnancy?: Yes  No  If yes, please explain: \_\_\_\_\_

Have you had any of the following symptoms during this pregnancy that have been a significant problem for you?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Nausea: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue: _____
<input type="checkbox"/>	<input type="checkbox"/>	Burning with urination: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal or pelvic pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal discharge: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vulvar itching or irritation: _____
<input type="checkbox"/>	<input type="checkbox"/>	Sore breasts: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge or breast lump: _____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever or chills: _____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath: _____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeats: _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion, heartburn or abdominal pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools: _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression: _____
<input type="checkbox"/>	<input type="checkbox"/>	Change in a mole: _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in swallowing: _____
<input type="checkbox"/>	<input type="checkbox"/>	Leg or hand swelling: _____
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids: _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to rubella or other viral illnesses: _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any drugs: _____
<input type="checkbox"/>	<input type="checkbox"/>	Prescription drugs: _____
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drugs: _____

Have you had any X-rays or other radiation exposure during this pregnancy?: Yes  No

If yes, please explain: \_\_\_\_\_

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## MEDICAL HISTORY

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Are you allergic to any drugs?: Yes  No  What happened?: \_\_\_\_\_

Have you had any of the following?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Serious accident or illness: _____
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic or hip fracture: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion: _____

Have you had any of the following problems?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous or mental problem: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic complications: _____
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection: _____
<input type="checkbox"/>	<input type="checkbox"/>	German measles: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures: _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches: _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure: _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast abnormalities: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones: _____
<input type="checkbox"/>	<input type="checkbox"/>	Deep venous thrombosis (blood clots in your legs): _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding abnormalities: _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis: _____

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### **HABITS**

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<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	When was the last time you had a cigarette? _____ How many packs do you smoke a day? _____ How old were you when you started smoking? _____
<input type="checkbox"/>	<input type="checkbox"/>	When was the last time you had a drink of alcohol? _____ What is the average number of drinks per week? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used street drugs? _____ Marijuana, cocaine, crank? Have you ever put drugs in your veins? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your partner a heavy drinker? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt you ought to cut down on your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have people annoyed you by criticizing your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt bad or guilty about your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener)
<input type="checkbox"/>	<input type="checkbox"/>	Do you use seatbelts? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly? _____

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### **SOCIAL HISTORY**

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<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Are there any family or social problems you feel I should know about? Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your partner supportive of your pregnancy? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does he plan to be present with you at your baby's birth? _____

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### **FAMILY HISTORY**

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Do any of the following disease run in your family?

<u>Yes</u>	<u>No</u>	If yes, please describe type and relative involved:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis: _____

**FAMILY HISTORY (cont.)**

- Do any of your relatives have Down's Syndrome (Mongolism) or any other chromosomal abnormalities that you know of?
- Are there any twins in your family?
- Does any member of your extended family have a cleft lip or palate, pyloric stenosis, congenital heart disease, neural tube defects (Spina Bifida or other types), clubbed feet, Cystic Fibrosis, PKU, Muscular Dystrophy, Hemophilia or any other known birth defects or abnormalities?
- Did any of your relatives require surgery in the first year of life?  
If yes, please describe: \_\_\_\_\_
- Is there a family history of mental retardation?
- If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
- If you or the baby's father are black, have either of you been screened for sickle cell trait?
- If you or the baby's father are Italian, Greek or Mediterranean background, have either of you been tested for  $\beta$ -thalassemia?
- If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for  $\alpha$ -thalassemia?
- Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (including nonprescription drugs)?  
If yes, give name of medication and time taken during pregnancy: \_\_\_\_\_

**PAST PREGNANCIES:**

1. Please describe all your prior pregnancies, including date, live birth (yes or no), sex of child, name of child, weight of child, hospital where child was born, method of delivery (C-section or vaginal) any pre-term labor with the pregnancy and any complications during pregnancy, labor or delivery.

	First	Second	Third	Fourth	Fifth
Date					
Live birth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>
Name					
Weight					
Place of birth					
Duration of active labor					
Any complications during pregnancy, labor or delivery (please describe)					

(If more than five pregnancies, please complete on separate sheet)

Who is going to be your baby's doctor?: Pediatrician \_\_\_\_\_ Family doctor \_\_\_\_\_

Are you going to: Breast feed?  Bottle feed?

Is there anything about your prior pregnancy (or pregnancies), labor or delivery experiences you would or would not want repeated?: (please explain) \_\_\_\_\_

Is there anything else you feel your doctor should know about you, your partner or your family? \_\_\_\_\_