

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

FULL NAME \_\_\_\_\_ BIRTHDATE month/day/yr \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

MARITAL STATUS    S    M    D    W    SPOUSE'S NAME & BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

YOUR ETHNIC ORIGIN \_\_\_\_\_ SPOUSE'S ETHNIC ORIGIN \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

CARE CARD # \_\_\_\_\_ *Where do you plan to deliver?* \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ SPECIALIST \_\_\_\_\_

PRESENT PREGNANCY

DATE OF LAST MENSTRUAL PERIOD: \_\_\_\_\_ WAS IT A NORMAL PERIOD FOR YOU? \_\_\_ YES \_\_\_ NO

ARE YOUR PERIODS REGULAR? HOW MANY DAYS? \_\_\_\_\_ Expected Due Date? \_\_\_\_\_

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING ? (CIRCLE)

PRESENT PREGNANCY:	PAST HEALTH		
ANEMIA	ABNORMAL PAP TEST	HIGH BLOOD PRESSURE	TAKING FOLIC ACID? HOW MUCH? _____
ALCOHOL / DRUG USE	ASTHMA	HYPOGLYCEMIA	DATE FOLIC ACID STARTED? _____
BLEEDING / SPOTTING	BLADDER INFECTION	MEASLES / RUBELLA	SPECIAL DIET? _____
BLOOD CLOTS	BLEEDING TENDENCIES	MENTAL DISORDER	WHEN WAS YOUR LAST PAP EXAM? _____
DEPRESSION	BLOOD TRANSFUSION	MONONUCLEOSIS	HOSPITALIZATIONS & SURGERIES (YEAR & REASON)
FEVER	CHICKENPOX	REACT TO ANESTHETICS	_____
HIGH BLOOD PRESSURE	DEPRESSION	SEXUAL ABUSE	_____
INFECTIONS	DIABETES	SEXUALLY TRANSMITTED	_____
NAUSEA	EATING DISORDER	INFECTIONS	_____
SMOKER? (Y OR N)	EPILEPSY	THYROID PROBLEMS	HEIGHT _____ PREPREGNANCY WEIGHT _____
VARICOSE VEINS	HEMORRHAGE	YEAST / VAGINAL INFECTION	
	HERPES		

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)\* \_\_\_\_\_ BROTHERS (ages)\* \_\_\_\_\_

MOTHER (age)\* \_\_\_\_\_ SISTERS (ages)\* \_\_\_\_\_

\* If deceased, Please list age at death and circle.

HAVE ANY OF THE ABOVE HAD THE FOLLOWING ? (CIRCLE)

CANCER	STROKE	GALLBLADDER DISEASE
DIABETES	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
INHERITED DISEASE/DEFECT		BLEEDING DISORDERS
ALCOHOLISM/DRUG ABUSE	DEPRESSION/PSYCHIATRIC ILLNESS	

CHILDBIRTH HISTORY

NUMBER OF PREGNANCIES \_\_\_\_\_ NUMBER OF CHILDREN \_\_\_\_\_

MISCARRIAGES \_\_\_\_\_ TERMINATIONS \_\_\_\_\_ TWINS \_\_\_\_\_

MONTH & YEAR OF BIRTH \_\_\_\_\_

\_\_\_\_\_

COMPLICATIONS \_\_\_\_\_

\_\_\_\_\_

BIRTH CONTROL METHODS: \_\_\_\_\_

KNOWN ALLERGIES (include medicines, pollens, animals, foods & chemicals): \_\_\_\_\_

CURRENT MEDICATIONS (list all prescription & over the counter medicines, **vitamins, minerals, herbs** that you take and doses): \_\_\_\_\_