Client Registration

This information will be used to complete the birth certificate and to help us provide you with optimal care.

Client Info:	First		Middle			Last		Maiden Name		Date
Race	Religion	Yrs Education	Marital Status	Occupation		Date of Birth		State of Birth	SSN	
Address			City	State	ZIP	Township		County	Phone	
Father of Baby Info:	First		Middle			Last		Partner/Husband Name *(if different from Father)*		
Race	Religion	Yrs Education	Marital Status	Occupation		Date of Birth		State of Birth	SSN	
Address (if different from above)			City	State	ZIP	Phone			SSN Requested for baby ? ☐ Y ☐ N ☐ Unsure	
Please, list another person to contact in the event of an emergency			Name:			Phone			Relationship	
Do you have health insurance? Are you on/eligible for Medicaid? Are you on/eligible for WIC?		☐ Y ☐ N ☐ On ☐ Eligible ☐ ? ☐ On ☐ Eligible ☐ ?	Policy Holder	Insurance Company		Policy #			Group #	

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

FAMILY HISTORY—*Indicate if anyone in your immediate family has ever had any of these including who and when*

☐ High Blood Pressure__________________________

☐ Cancer__________________________

☐ Diabetes__________________________

☐ Twins__________________________

☐ Severe emotional problems__________________________

☐ Alcohol/drug use__________________________

☐ Other__________________________

FATHER OF BABY (FOB)—*Indicate if the baby's father has ever had any of these and when*

☐ Sexually transmitted diseases__________________________

☐ Herpes: ☐ Genital ☐ Oral

☐ Severe emotional problems__________________________

☐ Alcohol/drug use__________________________

☐ Tobacco use__________________________

☐ Other__________________________

YOUR MOTHER'S HISTORY—*Please answer the following regarding your mother's history (not you)*

☐ # of pregnancies__________________________

☐ # of births__________________________

☐ Miscarriages__________________________

☐ Any complications__________________________

☐ Your weight at birth__________________________

☐ Did she take DES when pregnant with you?

☐ Yes ☐ No (was last used in the 1970's)

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

Date	# Weeks	Birth/Miscarriage/Termination	Comments/Problems
			☐ See Additional List for more

Yes No Have you of the father of the baby (FOB) ever had a baby with a birth defect or mental delay?
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 and the FOB related by blood? (e.g., cousins)
Yes No Are you or the FOB from any of the ethnic/racial groups? (circle one) Jewish Black/African Asian Mediterranean
Yes No Have you or the FOB ever had hepatitis of 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 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 AIDS/HIV?
Yes No Have you ever experienced dramatic fluctuations in your weight?
Yes No Have you ever had anorexia, bulimia, or other eating problems?
Yes No Is there anything about the development of your sexuality that you'd like to discuss?
Yes No Have you ever been in an abusive relationship, including now, or been abused (physically, emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
Yes No Have you ever had severe emotional problems?
Yes No Have you ever been on any medication for psychological 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 and 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
- ☐ Skin disorders
- ☐ Stomach problems
- ☐ Ulcers
- ☐ Chicken Pox
- ☐ 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
- ☐ Cancer
- ☐ Hospitalizations
- ☐ Surgeries
- ☐ Rubella
- ☐ Other ____

Do you have any allergies? ☐ Yes ☐ No

Please list allergy and reaction:

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GYNECOLOGIC HISTORY

Age at first period ______________

Cycle length (days) ______________

Regular? ☐ Yes ☐ No

Duration ____________________

Have you ever had a pelvic exam?
☐ Yes ☐ No

When was you last Pap smear?

____

Have you ever had an abnormal Pap?
☐ Yes ☐ No

Please describe

____

Please indicate if you have ever had any of the these and when:

- ☐ Yeast
- ☐ Trichomoniasis
- ☐ Group B Strep
- ☐ Bacterial vaginosis (BV)
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ PID/Pelvic infection
- ☐ Genital Sores
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Condyloma (genital warts)
- ☐ Cervicitis
- ☐ Cervical Surgery
- ☐ Cervical Polyp
- ☐ Ovarian cyst
- ☐ Fibroids
- ☐ Endometritis
- ☐ Abnormal bleeding
- ☐ Uterine surgery
- ☐ Breast lump(s)
- ☐ Breast surgery
- ☐ Infertility
- ☐ Other____________________

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

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PRESENT PREGNANCY

Last menstrual period (1st day)__________________ Normal ? ☐ Yes ☐ No

Suspected date of conception____________________________________

Pregnancy test (date)____

Planned pregnancy? ☐ Yes ☐ No

Feelings about pregnancy_______________________________________

Most recent birth control used____________________________________

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

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Please indicate if you've had any of the these problems during this pregnancy:

- ☐ Nausea
- ☐ Vomiting
- ☐ Fever
- ☐ Infections
- ☐ 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
- ☐ Depression
- ☐ Loneliness
- ☐ Family/relationship problems
- ☐ Work problems
- ☐ Other______________________

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

- ☐ Tobacco
- ☐ Alcohol
- ☐ Caffeine
- ☐ Marijuana
- ☐ Cocaine
- ☐ Street drugs
- ☐ Other meds
- ☐ Non-prescription meds
- ☐ Vitamins
- ☐ Herbs
- ☐ Fumes/sprays
- ☐ X-rays
- ☐ Ultrasound
- ☐ Measles/Viruses
- ☐ Travel
- ☐ Vaccinations
- ☐ Cats
- ☐ Other______________________

Planned place of birth:

☐ Home ☐ Birth Center ☐ Hospital

If home, please indicate if you have:

☐ Water ☐ Electricity ☐ Telephone

☐ Wi-Fi (internet access) ☐ Cellular Service at your house

Please use this space to add any other information:

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