Name_____ Date: _____

Please answer the following questions as best as you can. If you are unsure about a question, let us know when we call you into a room. All of your answers will be kept confidential. If you are unable to fill out this form, please let the front desk know.

1. What was the first day of your last period? _____/_____/_____ (If unsure, please give an estimated month and day. (month) (day) (year)

2. Is this your first pregnancy? Yes_____No_____ If yes, please to go question #3.
   How many times have you been pregnant (including your current pregnancy)?_____
   How many children do you have? _____
   List any problems or complications you have had with pregnancies or deliveries:_____
   _____

3. Have you see a doctor or been to the ER during this pregnancy? Yes_____No_____
   If yes, which hospital? _____ Date(s) you were seen:_____

4. Have you had any problems so far during this pregnancy? Yes_____No_____
   If yes, please explain: _____

5. Are you allergic to any medicine? Yes_____No_____ If yes, what medicine(s)? _____
   _____

6. Check any medical problems you have had, and explain if needed:

_____Asthma	_____High blood pressure	_____Diabetes
_____Seizures	_____Kidney disease	_____Hepatitis
_____Blood blotting problems	_____Sickle cell	_____Thyroid problems
_____Depression	_____Drug abuse	_____Alcohol abuse

Other_____

7. List any surgeries you have had (gallbladder, appendix, C-section)_____
   _____

8. List any medicines you take, with dosage: _____

9. Do you have any religious objection to a blood transfusion? _____
10. Do you smoke? Yes_____No_____ How many packs per day? _____
11. Do you drink alcohol? Yes_____No_____ How many drinks per week? _____
12. Do you use any street drugs? Yes_____No_____ Describe: _____
13. Have you or your sexual partner travelled outside of the country in the last 6 months?_____
    Do you plan to?_____ If so, where and when?_____
14. Have you or the father of your baby had any birth defects in your children or family members?
    Yes_____No_____ Check any that may apply:

_____Thalassemia	_____Neural tube defects/spina bifida
_____Heart defects	_____Down syndrome
_____Sickle cell	_____Blood clotting disorders
_____Mental retardation	_____Other genetic problems

15. Have you had genital herpes, hepatitis, HIV, or syphillis in the past? Yes_____No_____
16. What is the name and location of the pharmacy you use? _____
    _____

Thank you for taking the time to fill out this form. We appreciate your trust and the opportunity to provide you with the best possible care.