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

FULL NAME _____ BIRTHDATE month/day/yr _____/_____/_____ AGE _____

MAIDEN NAME _____ MARITAL STATUS S M D SPOUSE'S NAME & AGE _____

YOUR ETHNIC ORIGIN _____ SPOUSE'S ETHNIC ORIGIN _____

ADDRESS _____ CITY _____ POSTAL CODE _____

OCCUPATION _____ Spouse's Occupation _____

HOME PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

CARE CARD # _____ *Where do you plan to deliver?* _____

FAMILY PHYSICIAN _____ SPECIALIST _____

PRESENT PREGNANCY

FIRST DAY OF LAST MENSTRUAL PERIOD: _____ WAS IT A "TYPICAL" 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)

CURRENT PREGNANCY:

ANEMIA
ALCOHOL USE
DRUG USE
BLEEDING / SPOTTING
BLOOD CLOTS
DEPRESSION
FEVER
HIGH BLOOD PRESSURE
INFECTIONS
NAUSEA
SMOKER? (Y OR N)
VARICOSE VEINS

PAST HEALTH

ABNORMAL PAP TEST
ASTHMA
BLADDER INFECTION
BLEEDING TENDENCIES
BLOOD TRANSFUSION
CHICKENPOX
DEPRESSION
DIABETES
EATING DISORDER
EPILEPSY
HEMORRHAGE
HERPES
HIGH BLOOD PRESSURE
HYPOGLYCEMIA
MEASLES / RUBELLA
MENTAL DISORDER
MONONUCLEOSIS
REACT TO ANESTHETICS
SEXUAL ABUSE
SEXUALLY TRANSMITTED INFECTIONS
THYROID PROBLEMS
YEAST / VAGINAL INFECTION

TAKING FOLIC ACID? HOW MUCH?_____

DATE FOLIC ACID STARTED?_____

SPECIAL DIET? _____

WHEN WAS YOUR LAST PAP EXAM? _____

HOSPITALIZATIONS & SURGERIES (YEAR & REASON)

_____

_____

HEIGHT _____ PREPREGNANCY WEIGHT _____

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
INHERITITED DISEASE/DEFECT		BLEEDING DISORDERS
ALCOHOLISM/DRUG ABUSE	DEPRESSION/PSYCHIATRIC ILLNESS	

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): _____

_____

_____

48 HOUR CANCELLATION POLICY IN EFFECT. ANY MISSED / RESCHEDULED APPOINTMENTS WITH LESS THAN 48 HOURS NOTICE

WILL RESULT IN A $30.00 FEE*. I UNDERSTAND THE TERMS AND CONDITIONS AS STATED ABOVE. SIGNATURE:* _____