

(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:	PAST HEALTH	TAKING FOLIC ACID? HOW MUCH? _____
ANEMIA	ABNORMAL PAP TEST	DATE FOLIC ACID STARTED? _____
ALCOHOL USE	ASTHMA	SPECIAL DIET? _____
DRUG USE	BLADDER INFECTION	WHEN WAS YOUR LAST PAP EXAM? _____
BLEEDING / SPOTTING	BLEEDING TENDENCIES	HOSPITALIZATIONS & SURGERIES (YEAR & REASON)
BLOOD CLOTS	BLOOD TRANSFUSION	_____
DEPRESSION	CHICKENPOX	_____
FEVER	DEPRESSION	_____
HIGH BLOOD PRESSURE	DIABETES	_____
INFECTIONS	EATING DISORDER	_____
NAUSEA	EPILEPSY	HEIGHT _____ PREPREGNANCY WEIGHT _____
SMOKER? (Y OR N)	HEMORRHAGE	_____
VARICOSE VEINS	HERPES	_____

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	

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: _____