

## Patient Information & Pregnancy Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County (CA only): \_\_\_\_\_ Occupation: \_\_\_\_\_

**PARTNER INFORMATION (if the patient is pregnant, then “partner” is the father of the pregnancy)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Occupation: \_\_\_\_\_

**PATIENT CONTACT INFORMATION:**

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

May we leave detailed voice messages that may include **confidential medical information and test results**?  NO  YES

If yes, please provide a confidential phone number: \_\_\_\_\_

Can we leave test results with anyone else?  NO  YES If yes, please provide information below:

Name: \_\_\_\_\_ Confidential #: \_\_\_\_\_

**REFERRING DOCTOR OR CLINIC INFORMATION:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

**PREGNANCY AND EXPOSURE INFORMATION**

Are you currently pregnant?  NO  YES **Due date:** \_\_\_\_\_

Have you taken any medications during this pregnancy (besides prenatal vitamins or Tylenol)?  NO  YES

If yes, please list:

\_\_\_\_\_

**Since becoming pregnant, have you had any:**

(or if not pregnant please check current exposures)

Recreational Drugs  NO  YES \_\_\_\_\_

Cigarettes  NO  YES \_\_\_\_\_

Alcohol  NO  YES \_\_\_\_\_

Fevers (greater than 101° F)  NO  YES \_\_\_\_\_

X-rays (other than dental)  NO  YES \_\_\_\_\_

**Do you have any of the following conditions?**

Diabetes?  NO  YES \_\_\_\_\_

A seizure disorder?  NO  YES \_\_\_\_\_

Lupus?  NO  YES \_\_\_\_\_

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_