



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 AND AUTHORIZATION:

Cell: _____ Home: _____ Work: _____

May we leave a detailed voice message that includes **confidential medical information and test results**? NO YES

If YES, check all that apply: Cell Home Work

If we are unable to reach you, is there another person with whom we can leave a detailed voice message that includes **confidential medical information and test results**: NO YES If YES, complete below:

Name: _____ Relationship: _____ Number: _____

•Patient has the right to revoke permission for the confidential voice mail

•Patient assumes responsibility for information left on the confidential voice mail

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

Are you adopted? NO YES

Is your partner adopted? NO YES

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

PATIENT SIGNATURE: _____ **DATE:** _____