Integrated GENETICS
LabCorp Specialty Testing Group

PATIENT INFORMATION & PREGNANCY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: ______________________ First: ______________________ Birth date (M/D/Y):______________ Age: ________

Address: ____ City: ____________________________________

State: ______ Zip: _____________ County (CA only): ______________ Occupation: _______________________________

PARTNER INFORMATION

Last Name: ______________________ First: ______________________ Birth date (M/D/Y):______________ Age: ________

Occupation: ______________________ Is your partner the biological father of the pregnancy? ☐NO ☐YES

If no, did you use a sperm donor? ☐NO ☐YES

PATIENT CONTACT INFORMATION AND AUTHORIZATION

Cell: ____________________________ Home: ______________________ Work: ________________________________

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

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 (PRIMARY OB/GYN) OR CLINIC INFORMATION

Name: _______________________________________ Phone: ____

Address: _____________________________________ City: __________________________________ State: _________

PREGNANCY AND EXPOSURE INFORMATION

Do you have or have you ever had any of the following?

Diabetes? ☐NO ☐YES
Seizure disorder? ☐NO ☐YES
Lupus? ☐NO ☐YES
Graves' disease or Hashimoto Thyroiditis or thyroid cancer? ☐NO ☐YES

Are you currently pregnant? ☐NO ☐YES

Due date: _____________________________________

Are you or the biological father of the pregnancy adopted?
☐NO ☐YES If yes, please specify: _______________

Do you take any medications on a regular basis? ☐NO ☐YES

If yes, please specify. If you are pregnant, please list any medications you have taken since conception (other than prenatal vitamins and Tylenol): __________

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Since becoming pregnant, have you had any:

Cigarettes ☐NO ☐YES ______________
Alcohol ☐NO ☐YES ______________
Recreational Drugs ☐NO ☐YES ______________
Fevers (greater than 101˚ F) ☐NO ☐YES ______________
X-rays (other than dental) ☐NO ☐YES ______________

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

PATIENT SIGNATURE: ____ **DATE:** _______________

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