Patient Information & Pregnancy Questionnaire

Last Names: _____ 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 Names: _____ 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 be (becoming pregnant, have you had any:
(Or if not pregnant please check current exposures)

Recreational Drugs ☐ NO ☐ YES _____

Cigarettes ☐ NO ☐ YES _____

Alcohol ☐ NO ☐ YES _____

Do you have any of the following conditions?

Diabete? ☐ NO ☐ YES _____

A seizure disorder? ☐ NO ☐ YES _____

Lupus? ☐ 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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