

Date	Name: First	Middle	Last	Maiden?
Phone: [home]	[work]		[cell]	
E-mail:		Alternate contact:		
Address:		City:	State:	Zip:
Mother-to-be date of birth:	Occupation:			
Emergency contact: Name		Phone:	Relationship:	
Partner's name: First	Middle	Last	DOB:	
Address (if different):		City:	State:	Zip:
Phone:	Occupation:			
Donor Name, if applicable:		Sperm Bank Name, if applicable:		
Donor Phone:		Sperm Bank Phone/Fax:		

Please answer the following questions to help us have a better understanding of your health history & enable us to provide the best prenatal care possible. This information is completely confidential.

Family History / Indicate if anyone in your immediate family (parents, siblings, kin) has ever had any of the below. If yes, specify who and when.

- High Blood Pressure
- Exposure to DES
- Diabetes
- Birth Defects
- Cancer
- Mental Illness
- Alcohol/Drug Abuse
- Thyroid Problems
- Other

Father of Baby / Donor

Indicate if the baby's father has ever had any of the below. If yes, when.

- Sexually Transmitted Infections
- Genital/Oral Herpes
- Mental Illness
- Alcohol/Drug Abuse
- Tobacco Use
- Other

Your Mother's History /

Please answer the following regarding *your* ownmother.

- ___ Number of Pregnancies
- ___ Number of Births
- ___ Number of Cesareans
- ___ Number of Premature Births
- ___ Number of Miscarriages
- Any Complications? _____

Did she take DES while pregnant with you? Yes / No

Genetic History / Please circle appropriate

- Yes No** Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation? If so, please describe:
- Yes No** Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited? If so, please explain:
- Yes No** Do you think you are at an increased risk for conceiving a baby with a birth defect or genetic problem?

Medical History / Please indicate if you have ever had any of the below. If yes, when.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Eye/Vision Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pelvic or Back Injuries |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ear/Hearing Problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Anemia | |

Yes No Do you have any allergies (drug or environmental)? Please list and describe severity and type of reaction:

Yes No Are you currently taking any medications or supplements? (prescription, herbal, vitamins, & OTC)
Please list and describe (name, dosage, frequency, reason for taking)

Yes No Do you exercise regularly? If yes, please describe the type of exercise, how often, how long, etc.

Yes No Are you currently under the care of a physician or other health care provider(s) (including alternative care such as chiropractic, homeopathy, acupuncture, massage, etc)?
If yes, please list provide name, service, reason for care, and length of time in care.

Gynecological History /

Age at first period: No. of days of bleeding: Cycle length (days): Date of last pap?

Yes No Do you generally have regular cycles?

Yes No Do you have cramping/pain during your cycles?

Yes No Do you examine your breasts? How often?

Yes No Do you douche?

Yes No Have you ever had an abnormal pap? Please describe and provide dates:

Please indicate if you have ever had any of the below. If yes, when.

- | | | |
|---|---|--|
| <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Group B Strep |
| <input type="checkbox"/> Bacterial Vaginosis | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> PID/Pelvic Infection | <input type="checkbox"/> Genital Sores |
| <input type="checkbox"/> Herpes: Oral Genital | <input type="checkbox"/> HPV or Genital Warts | <input type="checkbox"/> Cervicitis |
| <input type="checkbox"/> Cervical Surgery | <input type="checkbox"/> Cervical Polyp(s) | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Uterine Surgery | <input type="checkbox"/> Breast Lump(s) | <input type="checkbox"/> Breast Surgery |
| <input type="checkbox"/> Fertility Problems | <input type="checkbox"/> Other | |

Please indicate if you or the father/donor have used or been exposed to any of the following during the past three years:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Soy Diet | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Raw Meat |
| <input type="checkbox"/> Swimming Pools/Jacuzzi | <input type="checkbox"/> Lead | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Aspartame | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Street drugs |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Non-pres. Drugs | <input type="checkbox"/> X-Rays |
| <input type="checkbox"/> Other meds | <input type="checkbox"/> Fumes/sprays/pesticides | <input type="checkbox"/> Mercury |
| <input type="checkbox"/> Herbs | <input type="checkbox"/> Measles/Viruses | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Other |

If prior pregnancy, previous pregnancy outcomes / Please complete this table regarding your own pregnancies

Date Ended	No. weeks	Comments- If birth, type of delivery, weight, sex, and name of baby, medications/interventions, complications, length of breastfeeding, procedures or surgery, if any.

Name:

Date:

Please fill out the information below to help us get a general idea of your eating habits:

I usually consume...	Every Day	Almost every day	3-4 times a week	Once or twice a week	Almost never	Never
Breakfast						
Lunch						
Dinner						
Snacks						
Canned vegetables						
Frozen vegetables						
Fresh vegetables						
• Leafy green						
• Yellow or orange						
Fresh Fruit						
Cheese or yogurt						
Soy or soy oils						
Eggs						
Red meat						
Iron rich foods						
Fish (note type)						
Chicken						
Beans, dried peas, or lentils						
Tofu or tempeh						
Nuts, peanut butter, tahini, etc.						
Other sources of protein?						
Whole grains, whole wheat noodles, brown rice						
White rice, spaghetti, noodles						
Items with refined sugar (candy, cake, cookies, etc.)						
Soda						
Caffeinated beverages						
Milk or soymilk						
Prenatal vitamins, type:						
Iron supplements, type:						
Calcium magnesium						

Do you microwave your food?

Are you craving any foods? Do you have any aversions to foods?

Are you vegan? If so, how long have you been?

Do you eat organic foods?

- ♥ If you have given birth before, how would you describe your past birth experiences? What would you change?

- ♥ Do you have any specific concerns, fears, or anxieties about having a (another) child in your life?

- ♥ How do you handle emotional issues in your life?

- ♥ Have you ever experienced and form of abuse (for example, domestic violence, rape, incest, emotional abuse)?

- ♥ Do you currently feel safe in your home, relationship, and workplace?

- ♥ Do you have any special requests about what you are seeking to get from our time together?

Please feel free to share anything else that you would like us to know on the bottom of this page or in person.

