High Risk Obstetrical Consultants

NEW PATIENT INFORMATION - PLEASE FILL IN ALL BLANKS

PATIENT INFORMATION

Name

Last ____ First ______________________________ Middle ____________________

Date of Birth ______/______/______ Sex _______ SSN ____________________ Race ____________________

Marital Status

Married ____ Single ____ Divorced ____ Other ____ Primary Language __________________ Religion __________________

Address ____

City __________________________ State ______ Zip __________

PHONE NUMBERS/CONTACT INFORMATION

Home ( ) ______________________ Work ( ) ______________________ Cell ( ) ______________________

E-mail ____

PHARMACY

Pharmacy Name ___________________________________ Location ____

Phone Number __________________________________

OTHER INFORMATION

Patient's Employer Name ____ Full-Time Part-Time Retired Not Employed

Phone # ( ) ______________________ Occupation ____

Father of baby/partner:

Name ____ Date of Birth ______/______/______ Race ____________________

Phone # ( ) ______________________ Occupation ____

How did you hear about us? Doctor ___ Friend ___ Facebook ___ Website/Google ___ Other ____________________________

Who is your primary OB/GYN provider? ______________________________ Which location? ____________________________

INSURANCE INFORMATION ☐ see copy of card

Insurance Company _______________________________________ Policy Holder___________________________________

Policy Number ______________________ Group Number ______________________

****I certify that the information contained herein is accurate and correct to the best of my knowledge.**

____ ____

Patient's Signature **Date**

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Please answer these questions as completely as you can. This information helps us to provide the best care for you and your baby.

Your name ________________________________ Reason for this visit _____________________________

Your date of birth ___________________________ How old will you be when the baby is due? __________

Name of baby's father ________________________ His age _______ Is he involved? Yes_____ No_____

- Do you or the baby′s father have a child with a major birth defect or problems? Yes______ No_____
  If yes, please explain: ____
- Do you or the baby's father have a genetic condition or birth defect? Yes______ No_______
  If yes, explain: ____
- Do you have any medical conditions such as diabetes or a thyroid problem? Yes______ No________
  Please explain: ____
- Are you and the baby's father related by blood? (i.e. cousins)? Yes_____ No_______
- Have you or the father of the baby had a child or a blood relative with any of these problems:

			Give details and indicate relationship to you.
Down syndrome	No	Yes	______________________________
Other chromosome disorder	No	Yes	______________________________
Spina bifida (open spine)	No	Yes	______________________________
Hydrocephaly (water on the brain)	No	Yes	______________________________
Hemophilia (free bleeder)	No	Yes	______________________________
Muscular dystrophy	No	Yes	______________________________
Cystic fibrosis	No	Yes	______________________________
Thalassemia	No	Yes	______________________________
Sickle cell disease	No	Yes	______________________________
Heart defect	No	Yes	______________________________
Cleft lip or palate	No	Yes	______________________________
Deaf/blind	No	Yes	______________________________
Any other inherited diseases	No	Yes	______________________________
Learning problems/ADD/ADHD	No	Yes	______________________________
Intellectual disability (formerly known as mental retardation)	No	Yes	______________________________

- What is your ancestry/ethnicity? (for example Italian, Irish, Hispanic, Jewish, African American, other)
  On your mother's side ____________________ On your father's side__________________________
- What is the baby's father's ancestry/ethnicity?
  On his mother's side________________________ On his father's side___________________________

- Do you or the baby's father have:

Jewish ancestry	No	Yes
African ancestry	No	Yes
Hispanic ancestry	No	Yes
Mediterranean ancestry	No	Yes
Middle Eastern ancestry	No	Yes
Asian or Southeast Asian ancestry	No	Yes
French Canadian ancestry	No	Yes

- Have you had any miscarriages? Yes______ No_______ If yes, how many? _______
- When was your last period?_____________ What is your due date? _________________
- Have you had an ultrasound this pregnancy? Yes______ No_______
- Were any problems seen on the ultrasound? Yes______ No_______
- In this pregnancy (including before you knew you were pregnant) have you:

		If yes, give details: (how much, when, name of medication).
Had alcohol?	No	Yes____
Smoked cigarettes?	No	Yes____
Used drugs?	No	Yes____
Taken vitamins?	No	Yes____
Taken prescription medications?	No	Yes____
Taken over-the-counter medications?	No	Yes____
Had X-ray or chemical exposure?	No	Yes____

- Have you or the baby's father had any genetic testing (such as cystic fibrosis carrier testing, sickle cell testing, Tay-Sachs carrier testing, chromosome study, CVS, amniocentesis, other)?
  If yes, list and give results:____
  ____
- Please list any questions or concerns that you have about your pregnancy, family history or medical history that have not been covered on this form. ____
  ____
- Please sign:

The information I have given on this form is complete and accurate to the best of my knowledge.

Signature: ___________________________________ Date: __________________