Client Registration

Name First	Middle		Last		Maiden?	Date	Phone (home) (work)
Race	Religion	Yrs Educ	Marital Status	Occupation/Type of Business		Date of Birth	State of Birth
Address: Street				City	Zip	Inside City Limits? ☐ Yes ☐ No	How long at this address?
Father of Baby: First	Middle		Last	Race	Yrs. Educ	Date of Birth	State of Birth
Address (if different from above)						Phone(work) (home)	Occupation/type of business
Partner/Husband (if different from Father)			Another person to contact in emergency Name:			relationship:	Phone:
Method of Payment: ☐ Medicaid ☐ Other : ☐ Cash			Insurance Information: Copay_____ Policy #			Name of Policy Holder: Group #	
Social Security Number	Father's SSN		SSN Requested for baby ☐ Yes ☐ No		Referred by:		

Please answer the following questions which will help determine if there are potential problems which should be discussed further. This information is completely confidential.

FAMILY HISTORY – *Indicate if anyone in your immediate family has ever had any of these, who; when.*

- ☐ High Blood Pressure_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Twins_____
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Other_____

FATHER OF BABY – *Indicate if the baby's father has ever had of these; when.*

- ☐ Sexually transmitted diseases_____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Severe emotional problems_____
- ☐ Alcohol/drug abuse_____
- ☐ Tobacco use_____
- ☐ 0ther_____

YOUR MOTHER'S HISTORY – ***Please answer the following regarding your mother:***

- ☐ No. of pregnancies_____
- ☐ No. of births_____
- ☐ Miscarriages_____
- ☐ Any complications_____
- ☐ Your weight at birth_____
- ☐ Did she take DES with you?
  ☐ Yes ☐ No

PREVIOUS PREGNANCY OUTCOMES *Please complete this table regarding your own pregnancies (from earliest to most recent)*

Date	#Weeks	Birth/Miscarriage/Termination	Comments/Problems

Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?

Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?

Yes No Are you and the FOB related by blood? (e.g., cousins)

Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)

Jewish Black/African Asian Mediterranean

Yes No Have you or the FOB ever had hepatitis or jaundice?

Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?

Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?

Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Yes No Do you think you are at increased risk for AIDS/HIV?

Yes No Have you ever experienced dramatic fluctuations in your weight?

Yes No Have you ever had anorexia, bulimia or other eating problems?

Yes No Is there anything about the development of your sexuality that you'd like to discuss?

Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?

Yes No Have you ever had severe emotional problems?

Yes No Have you ever been on any medication for psychological problems?

Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?