PATIENT INFORMATION

HIGH RISK Pregnancy CENTER OF KANSAS CITY

DATE: _____

Last Name | First Name | MI | DOB | Social Security #

Home Address | City, State | Zip

Home Phone | Cell Phone | Work Phone | Referring Provider

Marital Status

Occupation | Employer

Emergency Contact | Relationship | Phone #

Email Address (used for patient portal and lab results) | Leave Message on Home Phone? | Cell Phone?

Race : ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Other Race ☐ White/ Caucasian

Ethnicity : ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language : _____

INSURANCE INFORMATION : *Please provide insurance cards and Photo ID to front desk staff*

Primary Insurance Company | Policy Holder's Name | Relationship | DOB | Social Security #

Primary Policy Holder's Address

Secondary Insurance Company | Policy Holder's Name | Relationship | DOB | Social Security #

Secondary Policy Holder's Address

NAME : _____

Your Preferred Pharmacy Information :

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number _____

- **In addition to myself**, I authorize High Risk Pregnancy Center to speak with or leave messages with the following regarding my care or billing :

Name	Relationship	Phone Number
Name	Relationship	Phone Number

☐ High Risk Pregnancy Center may **NOT** speak with or leave messages with anyone else other than myself.

- High Risk Pregnancy Center has my permission to view my prescription history from external sources:

☐ YES ☐ NO

- I acknowledge that I have been offered and **DECLINED** a copy of this office's HIPAA Notice of Privacy Practices.

_____ _____

Signature ***Date***

NAME : _____

What is the reason for your visit? _____

CURRENT PREGNANCY

Date of Last Menstrual Period (LMP) : _____ Estimated Due Date: _____

Did you use fertility treatments for this pregnancy? ☐ YES ☐ NO

IF YES, what type(s) of treatment(s) :

☐ IVF ☐ IUI ☐ ICSI (Intracytoplasmic Sperm Injection) ☐ Ovulation Stimulation Only ☐ Other

List of medications used during fertility treatment (s) : _____

Pre-Genetic Implantation Testing Done? ☐ YES ☐ NO

PREGNANCY HISTORY

Date of Birth	Weeks at Delivery	Vaginal/C-Section	Sex	Gestational Complications/Diagnosis	Birth/Neonatal Complications	Birth Weight

MISCARRIAGES & ABORTIONS

Date	Weeks Pregnant	Miscarriage	Elective Abortion	Ectopic Pregnancy	With D & C
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS

Name	Dosage	Frequency

ALLERGIES

Medication	Type of Reaction

HEIGHT : _____

PAST MEDICAL HISTORY

Cardiovascular	☐ Arrhythmia ☐ Coronary Artery Disease ☐ Hypertension ☐ Stroke ☐ Blood Clots	Gastrointestinal	☐ Acid Reflux ☐ Gallbladder Disease ☐ Peptic Ulcer Disease ☐ Inflammatory Bowel Disease ☐ Hepatitis
Respiratory	☐ Asthma ☐ Cystic Fibrosis ☐ Pulmonary Embolism ☐ Sleep Apnea	Neurological	☐ Headaches/Migraines ☐ Seizures ☐ Multiple Sclerosis
Oncology	☐ Leukemia/Lymphoma ☐ Breast Cancer ☐ Cervical Cancer	Endocrine	☐ Diabetes ☐ Thyroid Disorder ☐ PCOS
Psychiatric	☐ Depression ☐ Schizophrenia ☐ Bipolar Disorder ☐ Anxiety	Immunologic	☐ Raynaud's ☐ Lupus ☐ Rheumatoid Arthritis ☐ Other Connective Tissue Disease ☐ HIV/AIDS
Renal	☐ Renal Disease ☐ Kidney Infection	Other Medical History: 1.) 2.) 3.) 4.) 5.)	
Hematologic	☐ Anemia ☐ Sickle Cell ☐ Thrombophilia ☐ Hemophilia ☐ Thrombocytopenia ☐ Blood Transfusions		

SURGICAL HISTORY

Date	Surgical Procedure		Date	Surgical Procedure

SOCIAL HISTORY

Tobacco Use : Never ☐

Former : How long since you last smoked? _____ Amount Per Day? _____

Current : How long have you smoked? _____ Amount Per Day? _____

Alcohol Use: Since Last Menstrual Period? How many? _____

Substance Use:

How long since you last used? ____ What Type? _____ Amount? _____

FAMILY HISTORY

Disorder/Conditions	Family Member	Type of Disorder/Treatment	Alive/Deceased
Cleft Lip/Palate			
Heart Defect			
Spina Bifida			
Blood Disorder			
Down Syndrome			
Other Chromosome Issues			
Tay-Sachs/Canavan Disease			
Cystic Fibrosis			
Mental Retardation/Developmental Delay			
Other Birth Defects/Genetic Disorders			