



DATE: \_\_\_\_\_

**PATIENT INFORMATION**

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Last Name	First Name	MI	DOB	Social Security #
Home Address		City, State	Zip	
Home Phone	Cell Phone	Work Phone	Referring Provider	
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*

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<b>Primary</b> Insurance Company	Policy Holder's Name	Relationship	DOB	Social Security #
Primary Policy Holder's Address				
<b>Secondary</b> 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 \_\_\_\_\_

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✚ **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
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_____	_____	_____
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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	<input type="checkbox"/> Acid Reflux <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> 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**

<b>Disorder/Conditions</b>	<b>Family Member</b>	<b>Type of Disorder/Treatment</b>	<b>Alive/Deceased</b>
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			