GENERAL HEALTH INFORMATION

Name:______________________________________Date of Birth: ________________

Social Security Number:________________________Due Date: __________________

Are you on a special diet? ____________If so, Explain:__________________________

Are you taking any medication? ________If so, list: _____________________________

Are you allergic to any drugs? ________If so, list: ______________________________

Are you allergic to any foods?________If so, list:________________________________

Do you have any other allergies?______If so, list: _______________________________

Explain symptoms of allergies and reactions:_____________________________________

____

What precautions and treatments do you use for your allergies: ___________________

____

Have you ever:

Been hospitalized? Yes_____ No_____ If yes, explain:__________________________

Had any surgery? Yes_____ No_____ If yes, explain:___________________________

Had electrocardiograms, or x-rays for diagnosis or treatment? Yes_____ No_____

If yes, explain: ____

Worn glasses or contacts? Yes_______ No________

Had any dental problems? Yes_____ No_____

Explain: ____

When was your last dental exam? ____

Have you ever had any of the following? Please circle if yes.

eye infections	liver disease	depression
thyroid disease	diverticulosis	childhood hyperactivity
hives or rashes	hernia	German measles
bronchitis	hemorrhoids	measles
pneumonia	scarlet fever	rheumatic fever
mumps	polio	mental illness
mononucleosis	STD's	chicken pox

Please write below any additional medical information we should know:

____

____

Did you have any complications that resulted from childhood diseases? :

____

____

Do you smoke cigarettes? Yes _______No ________

Have you consumed alcohol or used drugs since your pregnancy?: Yes____ No_____

Before your pregnancy? Yes_____ No_____

If so, What?: ____

____

How often?: ____

How much?: ____

Test and Immunizations: Please check those you have had and the year you were last given the test or immunization.

	(Year)			(Year)	
____	(______)	Chest x-ray	____	(______)	Tetanus shots
____	(______)	GI series	____	(______)	Polio series
____	(______)	Electrocardiogram	____	(______)	Flu injections
____	(______)	TB test	____	(______)	MMR shots
____	(______)	Smallpox shots	____	(______)	HIB shots

Have you had any previous pregnancies?

Live Births _______ Miscarriages ______ Abortions ______ Other ________________

Who should we contact in case of emergency?

Name:____________________________ Relationship to you?: ____________________

Address:____________________ City: _________________ Sate: ______ Zip:________

Phone: ________________Home ________________Work ________________Cell

Name:____________________________ Relationship to you?: ____________________

Address:____________________ City: _________________ Sate: ______ Zip:________

Phone: ________________Home ________________Work ________________Cell

FAMILY HISTORY

Please give us the following information about your parents:

Mother's Name: ________________________________

Address:__________________ City: ________________ Sate: _____ Zip:_______

Phone: ______________Home ______________Work ________________Cell

Place of Employment:____

Church Affiliation (if any):____

Marital Status: ____________

Any additional information you would like to share with us:____________________

____

____

Father's Name: ________________________________

Address:__________________ City: ________________ Sate: _____ Zip:_______

Phone: ______________Home ______________Work ________________Cell

Place of Employment:____

Church Affiliation (if any):____

Marital Status: ____________

Any additional information you would like to share with us:____________________

____

____

Please list your brothers and sisters, including in-laws, them and their ages:

____

____

Please give us the following information about your baby's' biological father:

Father's Name: ________________________________

Address:__________________ City: ________________ Sate: _____ Zip:_______

Phone: ______________Home ______________Work ________________Cell

Place of Employment:____

Church Affiliation (if any):____

Marital Status: ____________

Any additional information you would like to share with us:____________________

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