LISA TODD, LM AND KATHRYN BARRY, LM
CLIENT REGISTRATION FORM

CLIENT NAME First:	Middle:	Last:	Last name at birth:	Today's Date:	Mobile №
Preferred Pronoun:	Religious preference:		Email address:		Home №
Relationship Status:	Occupation:			Date of Birth:	Birthplace:
Address: Street		City	Zip	Health Insurance? Y N	Provider:
Partner Name First:	Middle:		Last:	Date of Birth:	Birthplace:
Preferred Pronoun	Partner's phone:			Occupation:	
Address: (if different from above)					
Last 4 digits of client's SSN: ___ ___ ___ ___			Referred By:		

IN CASE OF EMERGENCY

Emergency contact:	Relationship:	Phone:	Alternate phone:

Please answer the following questions, which will help determine if there are potential problems that should be discussed further. We use 'OBP' to refer to the Other Biological Parent/sperm donor (This information is completely confidential.)

FAMILY HISTORY: Indicate if anyone in your immediate family has ever had any of these conditions; who; when:

High Blood Pressure____________________

Cancer ________________________________

Diabetes_______________________________

Twins_________________________________

Severe emotional problems______________

Alcohol/Substance abuse________________

High Blood Pressure____________________

OTHER BIOLOGICAL PARENT OF BABY: Please indicate if the baby's OBP has ever had any of these; where; when:

Sexually transmitted disease_____________________

Herpes____

Genital Oral

Severe emotional problems_____________________

Alcohol/Substance abuse_______________________

Tobacco_______________________________________

Other____

YOUR BIRTH PARENT'S HISTORY: Please answer the following questions:

№ of pregnancies_____________________

№ of births_________________________

Miscarriages________________________

Any complications____________________

Your weight at birth___________________

PREVIOUS PREGNANCY OUTCOMES *Please complete this table regarding your own pregnancies (use other side of form if you need more room)*

Date	№ of weeks	Birth/Miscarriage/Termination	Comments/Problems

Yes	No	Have you or the Other Biological Parent (OBP) ever had a baby with a birth defect or mental retardation?
Yes	No	Do you or the OBP have any family members with birth defects or conditions diagnosed as genetic or inherited?
Yes	No	Are you and the OBP related by blood? (for example, cousins)
Yes	No	Are you or the OBP from any of these ethnic/racial groups (circle applicable): Jewish, Black/African, Asian, Mediterranean ?
Yes	No	Have you or the OBP 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 increased risk for HIV/AIDS?
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	Are you now, or have you ever been, on medication for psychological problems?
Yes	No	Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

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MEDICAL HISTORY: Please indicate if you have ever had any of these, and when:

Severe Headaches____________
Eye/Vision Problems__________
Ear/hearing problems_________
Dental problems_____________
Thyroid problems____________
Rheumatic fever_____________
Blood clotting problems_______
Anemia___________________
Hemorrhage________________
High blood pressure__________
Varicose veins______________
Hemorrhoids_______________
Tuberculosis________________
Asthma___________________
Skin disorders______________
Stomach problems___________
Ulcers____________________
Chicken Pox_______________

Bowel problems/colitis_________
Blood in stool________________
Gall bladder problems_________
Liver problems_______________
Hepatitis___________________
Diabetes___________________
Hypoglycemia_______________
Bladder infection_____________
Kidney infection______________
Urinary surgery______________
Urethral dilation______________
Aching joints________________
Pelvic/back injuries___________
Seizures___________________
Cancer____________________
Hospitalizations______________
Surgeries___________________
Other______________________

Do you have any allergies? Yes No

Please list:____

____

GYNECOLOGIC HISTORY

Age at first period_____________
Cycle length__________________
(№ of days between periods)
Regular? Yes No
Duration_____________________

When was your last Pap smear?
____
Have you ever had an abnormal Pap?
(dates) ____________________
Please describe_______________

Please indicate if you have ever had any of the following and when:

Yeast ______________________
Trichomonas _______________
Group B Strep _______________
Bacterial vaginosis ___________
Chlamydia __________________
Gonorrhea _________________
Syphilis ____________________
PID/Pelvic infection __________
Genital Sores _______________
Herpes: Genital
Oral
Condyloma (warts) ___________

Cervicitis ________________
Cervical surgery ___________
Cervical polyp _____________
Ovarian cyst _____________
Fibroids _________________
Endometriosis _____________
Abnormal bleeding ________
Uterine surgery ___________
Breast lumps _____________
Breast surgery ____________
Infertility ________________
Other ___________________

Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you'd like to discuss?

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PRESENT PREGNANCY

Last menstrual period (1st day)__________________________________
Suspected date of conception___________________________________
Pregnancy test (date)____
Is this a planned pregnancy? Yes No
Feelings about pregnancy______________________________________
Partner's Feelings____
Most recent birth control used__________________________________
Contraception used in past: what, when, any problems?
____
____

Please indicate if you have had any of the following problems with this pregnancy:

Nausea__________________
Vomiting_________________
Fever____________________
Infections________________
Headache________________
Dizziness________________
Indigestion_______________
Leg cramps_______________
Rash____________________
Backache________________
Swelling_________________
Constipation______________
Diarrhea_________________

Urinary complaints________________
Abdominal/pelvic pain_____________
Vaginal bleeding/spotting___________
Vaginal discharge_________________
Bleeding gums___________________
Varicose veins___________________
Hemorrhoids_____________________
Depression______________________
Loneliness______________________
Family/relationship problems_______
Work problems___________________
Other__________________________
____

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

Tobacco_________________
Alcohol__________________
Caffeine_________________
Marijuana________________
Cocaine_________________
Street Drugs______________
Other meds______________
Non-prescr. drugs__________
Vitamins_________________

Herbs_____________________
Fumes/Sprays______________
X-Rays____________________
Ultrasound________________
Measles/Virus______________
Travel____________________
Immunizations______________
Cats______________________
Other_____________________

Please indicate if you have the following at your home:

Water Electricity Telephone

Please use this space to add any other information regarding any of the above:

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