Premier Women's Health

Obstetrical Registration Form

Name: ____Date: ______________________

Date of birth:____Age:_________

Race: __________________Marital Status: __________________Years Married: ________

Home Address:____

City, State, Zip:____

Home Phone: ______________Work Phone: ______________Cell phone: ______________

Religion:______________Education:_______________ Social Sec. No.:________________

Occupation:___________________________Employer: ___________________________

Name of Father of baby: ____

His home phone:_____________His work phone:_____________Cell phone: ____________

Does he have any significant diseases, including congenital birth defects? If so, please list:

____

Family History: The following history pertains to YOUR side of the family only. If any of your family members have any of the following, please list which family member it is (mother, father, etc., also maternal or paternal).

1. Tuberculosis _______________________
2. Hypertension ______________________
3. Heart Disease ______________________
4. Diabetes____________________________
5. Neurological-Psychological Problems____
6. Epilepsy ___________________________
7. Allergies ___________________________
8. Multiple Births ______________________
9. Birth Defects _______________________

Menstrual History:

1. Age of first menstrual period_______
2. Menstrual flow occurs every _______days.
3. Menstrual flow lasts _______days.
4. Amount of flow (normal, heavy, etc.) ____
5. Date of last menstrual period ____
6. Was it a normal period? _______

Who is your Primary Care Physician?____
Has your Primary Care Physician been advised of your pregnancy? _______

What kind of insurance do you have? ____
(Please give your insurance card to the receptionist so copies can be placed in your medical record).

In case of Emergency, please notify:
____

Phone number:_____________________ Relationship to patient:_____________________