



HEALTHCARE CENTERS
of MORRIS HOSPITAL

Morris Hospital and Healthcare Centers Registration Form										
Last Name:		First Name:		M.I.:	Suffix:	Prefix: Maiden/Previous Name (if applicable):				
Date of Birth:		Birth Sex:	Legal Sex:	Social Security Number:		Primary Care Provider: Referring Provider:				
Home Phone Number:		Cell Phone Number:		Work Number:		Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work				
Address:			City:	State:	Zip:	Email:				
Patient Information	Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other: _____		Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*if a translator is needed, one will be provided.</i>		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		Race (please select one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other _____		Ethnicity (please select one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to Specify	
	Preferred Name:		Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Other: _____							
	Employer Name:				Employer Address:			Employer Phone #:		
	Advanced Directives: (If yes, please provide the office with a copy for your record) Living Will <input type="checkbox"/> Yes <input type="checkbox"/> No Resuscitation Status: _____ Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No Power of Attorney Name and Number: _____						Preferred Pharmacy Name and Location: (please include any mail order pharmacy)			

Primary Insurance Company:								
Subscriber Last Name:		Subscriber First Name:		M.I.:	Prefix:	Suffix: Relationship to Patient:		
Name on card (if different):		Subscriber DOB:		Birth Sex:	Legal Sex:	Social Security Number:		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		Race (please select one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other _____			Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other: _____		Citizenship: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:		Subscriber Address: <input type="checkbox"/> Same as Patient			City:		State:	Zip:
Home Phone:		Cell Phone:		Work Phone:		Policy ID:	Coverage Plan:	
Group Name:		Group Number:		Employment Status:		Employer Name:	Employer Location:	



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Secondary Insurance	Secondary Insurance Company:					
	Subscriber Last Name:	Subscriber First Name:	M.I.:	Prefix:	Suffix:	Relationship to Patient:
	Name on card (if different):	Subscriber DOB:	Birth Sex:	Legal Sex:	Social Security Number:	
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Race (please select one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other _____		Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other: _____		Citizenship: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Email:	Subscriber Address: <input type="checkbox"/> Same as Patient	City:		State:	Zip:
	Home Phone:	Cell Phone:	Work Phone:	Policy ID:	Coverage Plan:	
	Group Name:	Group Number:	Employment Status:	Employer Name:	Employer Location:	

Tertiary Insurance	Tertiary Insurance Company:					
	Subscriber Last Name:	Subscriber First Name:	M.I.:	Prefix:	Suffix:	Relationship to Patient:
	Name on card (if different):	Subscriber DOB:	Birth Sex:	Legal Sex:	Social Security Number:	
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Race (please select one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other _____		Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other: _____		Citizenship: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Email:	Subscriber Address: <input type="checkbox"/> Same as Patient	City:		State:	Zip:
	Home Phone:	Cell Phone:	Work Phone:	Policy ID:	Coverage Plan:	
	Group Name:	Group Number:	Employment Status:	Employer Name:	Employer Location:	



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Primary (Mother/Guardian 1)	Primary Emergency Contact (if under 18, please list both parents first)		
	Last Name:	First Name:	Relationship to Patient:
	Home Phone Number:	Cell Phone Number:	Work Phone Number:
Secondary (Father/Guardian 2)	Secondary Emergency Contact		
	Last Name:	First Name:	Relationship to Patient:
	Home Phone Number:	Cell Phone Number:	Work Phone Number:

Responsible Party/Guarantor	**Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor and is responsible for the bill. Statements will be sent to the responsible party listed. **					
	Guarantor Last Name:	Guarantor First Name:	M.I.:	Prefix:	Suffix:	
	Relationship:	Guarantor DOB:	Birth Sex:	Legal Sex:	Social Security Number:	Language:
	Email:	Address: <input type="checkbox"/> Same as Patient		City:		State: Zip:
	Home Phone:		Cell Phone:		Work Phone:	
	Employer Name:	Employer Address:	Employer City:	Employer State:	Employer Zip:	
	Employer Phone:	Employer Fax:	Employer Email:	Occupation:	Employment Status:	

Initials:

_____ I understand that it is the policy of the Healthcare Centers of Morris Hospital to be given at least 24 hour notice when canceling an appointment. I understand that more than 3 failures to cancel appointments without proper notice may result in being discharged from the practice.

_____ This Healthcare Center is a lab drawing station for Morris Hospital and all labs will be processed by the Morris Hospital laboratory. I am aware that my insurance may prefer or require an outside lab to be used for lab processing and that I am responsible for the charges that my insurance does not pay.

_____ I have read and been offered a current copy of the Notice of Privacy Practices.

_____ I have read and been offered a current copy of the Patient Rights and Responsibilities.

_____ I understand that my medication history will be verified electronically for treatment purposes.

_____ I understand that my immunization records will be sent electronically to the State of Illinois Immunization Registry.

Patient or Parent/Guardian Signature

Date

***By signing I attest to all information provided is true to the best of my knowledge.**



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MEDICAL & FAMILY HISTORY FORM

Name: _____

DOB: _____

Other Medical Providers	Specialty	Phone # / Location

ALLERGIES (List all known allergies, including medication, food, animals, seasonal, etc.)

None

Do you have a **latex** allergy? Yes No

Allergy	Reaction

MEDICATIONS Please list all of your current prescription and non-prescription medications, vitamins and supplements:

None

Medication	Strength	Frequency	When did you start medication?



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PAST MEDICAL HISTORY:

Birth History: (Pediatric patients only)

Birth weight: _____ Delivering Physician/Hospital: _____

Full-Term (>38 weeks) Vaginal C-Section due to _____

Premature (<38 weeks) # weeks _____ Forceps Vacuum

Pregnancy Concerns: _____ None Newborn Concerns: _____ Jaundice None

PAST MEDICAL HISTORY:

None

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Coronary Artery Disease /CAD | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Milk intolerance | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mumps | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> MRSA | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congestive Heart failure/ CHF | <input type="checkbox"/> Herpes | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Overweight | <input type="checkbox"/> Strep throat, multiple |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Parkinsons Disease | <input type="checkbox"/> Stroke or paralysis |
| <input type="checkbox"/> Bi-pap/C-pap use | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> TB – Tuberculosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Ear infections, multiple | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Peripheral Vascular Disease /PVD | <input type="checkbox"/> TB skin test positive |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Breast problem | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease /failure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Cancer, Type: _____ | <input type="checkbox"/> Fatty liver | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Urinary reflux |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Lupus | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Pyloric stenosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Gout | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatic fever | |
| | | | <input type="checkbox"/> RSV | |

SURGERIES/PROCEDURES

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Ovary |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> EGD | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Breast | <input type="checkbox"/> ERCP | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Kidney | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Groin hernia | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Liver biopsy | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Heart stent | <input type="checkbox"/> Obesity surgery/Gastric bypass | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Defibrillator /Heart pacemaker | <input type="checkbox"/> Heart valve | | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Hemorrhoid surgery | | |

PREVIOUS HOSPITALIZATIONS OR SERIOUS INJURIES

None

Hospitalization or Injury	Date

IMMUNIZATIONS

Pediatric Immunizations UNKNOWN Immunization history Immunization records available

Adult Immunizations/Vaccination Records UNKNOWN Immunization history

Check if received	Vaccination / Immunization	Date Received
<input type="checkbox"/>	Influenza /Flu	
<input type="checkbox"/>	Pneumonia	
<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	Shingles	
<input type="checkbox"/>	Other -	
<input type="checkbox"/>	Other -	

FAMILY HISTORY (Check the appropriate box to indicate which relative has had the following diseases)

Parents / Grandparents	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
NO KNOWN HEALTH ISSUES						
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						

Brothers / Sisters	<input type="checkbox"/> Brother	<input type="checkbox"/> Brother	<input type="checkbox"/> Brother	<input type="checkbox"/> Brother	<input type="checkbox"/> Brother	<input type="checkbox"/> Brother
	<input type="checkbox"/> Sister	<input type="checkbox"/> Sister	<input type="checkbox"/> Sister	<input type="checkbox"/> Sister	<input type="checkbox"/> Sister	<input type="checkbox"/> Sister
	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
NO KNOWN HEALTH ISSUES						
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						

# Sons _____ # Daughters _____	<input type="checkbox"/> Son	<input type="checkbox"/> Son	<input type="checkbox"/> Son	<input type="checkbox"/> Son	<input type="checkbox"/> Son	<input type="checkbox"/> Son
	<input type="checkbox"/> Daughter	<input type="checkbox"/> Daughter	<input type="checkbox"/> Daughter	<input type="checkbox"/> Daughter	<input type="checkbox"/> Daughter	<input type="checkbox"/> Daughter
	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
NO KNOWN HEALTH ISSUES						
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						

SOCIAL HISTORY

<p>Tobacco Use Screening:</p>	<p><input type="checkbox"/> Never <input type="checkbox"/> Current, Daily Smoker <input type="checkbox"/> Current, Some Days Smoker <input type="checkbox"/> Former Smoker <i>If current or former, what tobacco products do you use?</i> <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe</p> <p><i>If current or former cigarette smoker, how many cigarettes a day?</i> <input type="checkbox"/> number of packs per day _____ OR <input type="checkbox"/> number of cigarettes per day _____</p> <p><i>If current or former cigarette smoker, date/year started smoking</i> _____</p> <p><i>If former cigarette smoker, date/year quit smoking</i> _____</p> <p><i>If current or former cigarette smoker, number of years smoked</i> _____</p> <p><i>If former cigarette smoker, how long has it been since you smoked?</i> <input type="checkbox"/> less than 15 yrs ago <input type="checkbox"/> more than 15 years ago</p> <p><i>If current daily smoker, are you interested in quitting?</i> <input type="checkbox"/> Ready to Quit <input type="checkbox"/> Thinking About Quitting <input type="checkbox"/> Not Ready to Quit</p> <p>Do you use any of these nicotine containing products? <input type="checkbox"/> E-Cigarettes <input type="checkbox"/> Vaping Products <input type="checkbox"/> Smokeless Tobacco <input type="checkbox"/> Other: _____</p> <p><i>If you use smokeless tobacco, what product?</i> <input type="checkbox"/> chewing tobacco <input type="checkbox"/> Snuff <input type="checkbox"/> snus <input type="checkbox"/> dissolvable tobacco <input type="checkbox"/> Other: _____</p> <p>Do you have exposure to second hand tobacco smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Alcohol Use Screening:</p>	<p><i>Within the past year, how often did you have a drink containing alcohol?</i> <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 Times a Month <input type="checkbox"/> 2-3 Times a Week <input type="checkbox"/> 4 or More Times a Week</p> <p><i>Within the past year, how many standard drinks containing alcohol did you have on a typical day?</i> <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 5 or 6 <input type="checkbox"/> 7 to 9 <input type="checkbox"/> 10 or more</p> <p><i>Within the past year, how often did you have six or more drinks on one occasion?</i> <input type="checkbox"/> Never <input type="checkbox"/> Less Than Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or Almost Daily</p>
<p>Recreational Drug Use:</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Former <input type="checkbox"/> Cannabis (any form) <input type="checkbox"/> Cocaine <input type="checkbox"/> Amphetamines/Methamphetamines <input type="checkbox"/> Sedatives/Tranquiliers <input type="checkbox"/> Opioids/Painkillers <input type="checkbox"/> Club/Designer Drugs <input type="checkbox"/> Other: _____</p>
<p>Occupation:</p>	<p>_____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired</p>
<p>Education Level:</p>	<p>Highest grade level completed: <input type="checkbox"/> Pre-School <input type="checkbox"/> Grade School <input type="checkbox"/> Home School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Other: _____</p>
<p>Pets:</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes - Type: _____</p>
<p>Marital Status:</p>	<p><input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Other: _____</p>
<p>Living with:</p>	<p><input type="checkbox"/> Alone <input type="checkbox"/> Assisted Living <input type="checkbox"/> Foster Family <input type="checkbox"/> Grandparents <input type="checkbox"/> Group Home <input type="checkbox"/> Homeless <input type="checkbox"/> Institution <input type="checkbox"/> Intermediate Care Facility <input type="checkbox"/> Live-In Caregiver <input type="checkbox"/> Senior House <input type="checkbox"/> Significant Other <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> With Children <input type="checkbox"/> With Others: _____ <input type="checkbox"/> With Parent <input type="checkbox"/> With Spouse</p>
<p>Health Literacy:</p>	<p>Do you feel comfortable filling in medical forms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Special Considerations (Notes):</p>	<p>Any other special considerations pertaining to medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain _____</p>

GYN HISTORY

Date of Last Menstrual Period: _____

Age at first period: _____ Age of menopause: _____ N/A

Last Mammogram: Date: _____ Were the results normal Yes No

Last PAP Smear: Date: _____ Were the results normal Yes No

Have you ever had an abnormal PAP? Yes No

What were the results _____ What actions were taken (if any) _____

Have you had any of the following procedures/condition

Hysterectomy Colposcopy Cryo LEEP uterine anomaly

History of sexual activity (check all that apply):

None oral anal vaginal with men with women currently active not currently active sexual abuse

STDs Number of sexual partners: _____

Have you ever had any sexually transmitted diseases

none genital warts herpes chlamydia gonorrhea HIV trichomonas hepatitis syphilis HPV

Current form of contraception

none withdrawl condoms oral contraceptive pills hormonal IUD non-hormonal IUD diaphragm vaginal ring
 tubal ligation salpingectomy vasectomy depo-provera essure spermicide implant transdermal patch

Other previously used form of contraception (check all that apply)

none withdrawl condoms oral contraceptive pills hormonal IUD non-hormonal IUD diaphragm vaginal ring
 tubal ligation salpingectomy vasectomy depo-provera essure spermicide implant transdermal patch

OB HISTORY

Total number of Pregnancies (including miscarriages and abortions) _____

Total number of births _____

Number of Full-term Births _____ Number of Premature Births _____

Number of Abortions _____ Number of Miscarriages _____

Number of Multiple births _____ Total number of Living Children _____

Please enter your past pregnancies in the table below:

Delivery Date	Weeks Gestation	Delivery Type	Birth Weight	Infant Gender	Hours in Labor	Type of anesthesia	Location	Provider	Complications
		Vaginal	lbs	Male					
		C-Section	oz	Female					
		Vaginal	lbs	Male					
		C-Section	oz	Female					
		Vaginal	lbs	Male					
		C-Section	oz	Female					
		Vaginal	lbs	Male					
		C-Section	oz	Female					
		Vaginal	lbs	Male					
		C-Section	oz	Female					