



Thank you for choosing the Medford Women's Clinic for your obstetrical care. By following the suggested guidelines below, you will help us provide you with the best care and save you time at your appointment.

**Things to do before your appointment:**

- ✓ Fill out the enclosed information sheets. Remember to complete both sides. Answer all questions to the best of your ability.
- ✓ Contact your health plan insurance. In some cases, **obstetrical services are not covered by health insurance.** Please ask your health plan to see if they cover "obstetrical services."
- ✓ Please check with your Primary Care Provider to be sure a **referral** is sent to us prior to your appointment if one is needed.

**The day of your appointment:**

- ✓ Arrive **fifteen minutes** before your scheduled appointment.
- ✓ Have your insurance card and photo ID with you.
- ✓ Have your forms completed and here with you on your visit.
- ✓ Because the initial OB appointment can be up to two hours long, please arrive on time, and make arrangements for childcare. Feel free to bring your partner or spouse.
- ✓ If you are Private Pay, payment is due on the day of service.

If you are unable to keep this appointment, please give our office **at least** a twenty-four hour notice. Should you have any questions or need assistance in completing any of the forms, please contact our office. Thank you for selecting us to help you with your health care needs.



**Patient Registration**

Date: \_\_\_\_\_

LEGAL NAME:				DATE OF BIRTH:	
SOCIAL SECURITY:		MARITAL STATUS:		SEX:	
HOME PHONE:		CELL:		EMAIL:	
ADDRESS:					
RACE:	White Asian Black Pacific Islander American Indian Other: _____				
ETHNICITY:	Hispanic or Latino Non-Hispanic or Non-Latino				
PREFERRED PHARMACY:	(name and city)				
EMPLOYER:					
OCCUPATION:		WORK PHONE:			
HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME? Yes No IF YES, UNDER WHAT NAME? _____					
EMERGENCY CONTACT NAME:				Phone:	
RELATIONSHIP:					
<b>GUARANTOR (RESPONSIBLE PARTY if different from patient) OR CUSTODIAL PARENT</b>					
NAME:			ADDRESS:		
HOME PHONE:		SS#		DATE OF BIRTH:	
EMPLOYER:				OCCUPATION:	
RELATIONSHIP:				WORKPHONE:	
<b>PROVIDER INFORMATION</b>					
Primary Care Physician:					
REFERRING DR:					
<b>INSURANCE INFORMATION</b>					
I HAVE: MEDICARE    MEDICAID CARD    HEALTH INSURANCE    NO INSURANCE					
MEDICARE ID# _____			OREGON HEALTH PLAN ID# _____		
<b>Primary Insurance Information</b>					
NAME:			ADDRESS:		
ID/POLICY #:			GROUP #:		
INSURED NAME:			DOB:	SEX:	
RELATIONSHIP TO PT:			EMPLOYER:		
<b>Secondary Insurance Information</b>					
NAME:			ADDRESS:		
ID/POLICY #:			GROUP #:		
INSURED NAME:			DOB:	SEX:	
RELATIONSHIP TO PT:			EMPLOYER:		

I give permission for you to share any information in my medical history with: \_\_\_\_\_

I authorize the medical treatment of this patient. \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents under 18, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
(authorized signature of subscriber)

hereby authorize \_\_\_\_\_ to pay and hereby assign  
(name of ins co.)

Medford Women's Clinic, LLP all benefits, if any, otherwise payable to me for my physician's services.



3170 State Street
Medford, OR 97504-8450
(541) 864-8900

Med Rec #: \_\_\_\_\_

Please fill out all below:

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Date \_\_\_\_\_

Referring physician \_\_\_\_\_

Occupation (past and present) \_\_\_\_\_ PCP \_\_\_\_\_

Reason for coming to the Clinic \_\_\_\_\_

Marital Status \_\_\_\_\_ Next of Kin \_\_\_\_\_ Phone # \_\_\_\_\_

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- Diabetes, Heart disease, High blood pressure, Cholesterol problem, Lung disease, Ulcers, Brain or nerve disease (stroke), Liver disease or hepatitis, Arthritis, Tuberculosis, Cancer, Blood clots or phlebitis, Depression/Anxiety, Kidney disease/stones, Acid reflux or hiatal hernia, Migraine, Environmental allergies, Seizures, Asthma, Tuberculosis or abnormal skin test, Osteoporosis, Thyroid disorder, Sexually transmitted disease, Other

Operations/Hospitalizations (includes tonsillectomy and appendectomy)

Table with 3 columns: Date, Operation/Hospitalization, Complications

Severe Accidents and Injuries

\_\_\_\_\_

Allergies and Adverse Medication Reactions (please list reaction)

\_\_\_\_\_

Tobacco Use? No Yes Pkgs/day # years Quit? Year quit

Alcohol Use? No Yes Drinks/day Drinks/week Beer Wine Hard liquor

Have you used recreational drugs? No Yes

Date of last use? \_\_\_\_\_

Last menstrual period Last pap smear Last mammogram

Number of pregnancies Number of births Contraception

Including vasectomy

Irregular periods Abnormal pap smear Painful periods Heavy periods Tubal ligation

MEDICATIONS CURRENTLY TAKEN regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin - with dosage.

\_\_\_\_\_

Glasses milk/day? Last osteoporosis scan Calcium supplements (mg/day)?

Flu shot No Yes When How often do you exercise?

Tetanus booster No Yes When What is your workout?

Pneumonia vaccine No Yes When

Hepatitis B vaccine No Yes When Date of last colonoscopy?

Gardasil vaccine No Yes When Date of last endoscopy?

SEE REVERSE SIDE

## FAMILY HISTORY

	Age of death	Age if alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			

Significant Illness in Grandparents, Cousins, Aunts, Uncles or Children?

\_\_\_\_\_

\_\_\_\_\_

Check if any of these illnesses run in the family.

	No	Yes
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>

**REVIEW OF SYSTEMS: Do you have, or have had in the past month, any of the following? (Place a check mark next to those you have experienced).**

**General**

- Recent fever
- Weight loss
- Weight gain
- Night sweats
- Loss of energy
- Trouble sleeping

**Skin**

- Rashes
- Changes in mole

**Blood**

- Easy bruising
- Transfusions

**Nose and Mouth**

- Tooth pain
- Sore throat
- Sinus pain
- Nasal congestion

**Breasts**

- Discharge from nipples
- Lumps
- Breast pain

**Cardiovascular**

- Chest pain
- Leg swelling
- Heart murmur
- Palpitations
- Varicose veins

**Pulmonary**

- Shortness of breath
- Wheezing
- Cough
- Cough up blood

**Digestive**

- Poor appetite
- Gas or heartburn
- Nausea
- Vomiting
- Abdominal pain or cramping
- Constipation
- Diarrhea
- Hemorrhoids
- Rectal bleeding

**Genitourinary**

- Burning on urination
- Bloody urine
- Incontinence
- Infections
- Difficulty urination
- Urination at night: # times \_\_\_\_\_
- Multiple sexual partners

**Skeletal**

- Fractures
- Arthritis
- Back or neck pain

**Brain and nerves**

- Dizziness
- Blackouts
- Headaches
- Depression
- Anxiety, excessive worry

Is there anyone that you're afraid of? \_\_\_\_\_

Source of stress? \_\_\_\_\_

Do you have an Advanced Directive for end-of-life? \_\_\_\_\_



## Acknowledgment and Consent for Treatment

I understand that Medford Women's Clinic (MWC) will use and disclose health information about me.

I understand that my health information may include information both created and received by MWC, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that MWC may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how MWC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of MWC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of MWC's Notice of Privacy Practices in effect will be posted in the waiting/ reception area.

I would like to be informed of any clinical studies that may enhance my medical treatment. I authorize my medical information, securely and confidentially, transferred to the Advanced Clinic Research department affiliated with the Medford Women's Clinic. Initial Here: \_\_\_\_\_ I agree

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that MWC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

By \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient Representative)

Description of Representative's Authority: \_\_\_\_\_  
 Effective March 2009



*Medford*  
**WOMEN'S CLINIC** LLP  
 o b s t e t r i c s   a n d   g y n e c o l o g y

**Financial Policy of Medford Women's Clinic**

Thank you for choosing Medford Women's Clinic (MWC). If you do not understand our financial policy please feel free to ask our patient billing representative for clarification.

- Your financial responsibility is to provide payment for services rendered.
- Come prepared to pay in full if your insurance deductible has not been met.
- It is your responsibility to provide accurate billing information, we bill your insurance as a courtesy. Should you not give us accurate information it will be your responsibility to pay in full.
- Payment options are: Cash, Check, Visa, Mastercard, Discover, American Express, and Care Credit.
- Returned checks will be subject to our bank's NSF fee. Currently this is \$50.
- Should your account become delinquent a collection fee will be assessed. No-Shows will also be charged a fee.
- For patients who have made payment arrangements and the account is older than 60 days will receive a service charge of 1.5% per month (18% annual) until the account is paid in full.
- Labs and Hospital charges are billed separately and you will receive a separate statement for those costs.
- Minor children are the parent's responsibility for all services rendered.
- Pre-authorization /Second Opinions/Referrals are your responsibility. Our Billing Department will assist you in this effort.
- By signing below you are giving authority to MWC to release any information required to complete your insurance claim. This is in effect until it is revoked in writing.
- By signing below you understand this policy and are bound by it.

Email Address \_\_\_\_\_, Does MWC have permission to contact you through your email address? \_\_\_\_\_yes \_\_\_\_\_no

Patient or Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

This policy is subject to change

## OBSTETRICAL DATABASE

### GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Primary Phone Number: \_\_\_\_\_ Work/Other Phone Number: \_\_\_\_\_  
Referred By: \_\_\_\_\_ PCP: \_\_\_\_\_  
Religion: \_\_\_\_\_  
Your Occupation: \_\_\_\_\_  
Education Level: 10 11 12 College 1 2 3 4 4+ Other: \_\_\_\_\_  
Marital Status: Single  Married  Divorced  Widowed  Other: \_\_\_\_\_  
Partner Name: \_\_\_\_\_ Partner Occupation: \_\_\_\_\_  
Hobbies: \_\_\_\_\_

### GYN HISTORY

Age at onset of menstruation: \_\_\_\_\_  
Number of days between typical period: \_\_\_\_\_  
Are you menstrual periods usually regular? Yes  No  If no, please explain: \_\_\_\_\_  
First day of your last menstrual period? \_\_\_\_\_ Certain: Yes  No   
Is this a planned pregnancy?: Yes  No   
What form(s) of contraception have you used in the past? Birth Control Pills, IUD, Nexplanon, Depo,  
Diaphragm, Rhythm Method, Condoms or Abstinence.  
Recent IUD? If yes, date removed?: \_\_\_\_\_  
Have you ever been treated for any sexually-transmitted infections? Chlamydia, Gonorrhea, Herpes, Trichomonas, Syphilis?  
\_\_\_\_\_  
When/where was your last pap smear? \_\_\_\_\_  
Have you ever had an abnormal pap smear? If yes, please explain: \_\_\_\_\_  
Have you ever had any surgery on your female organs? If yes, please explain and give dates: \_\_\_\_\_  
\_\_\_\_\_  
Did your mother take DES when she was pregnant with you? Yes  No  Uncertain   
How tall are you?: \_\_\_\_\_  
What is your partner's weight and height?: \_\_\_\_\_  
Is this your partner's first baby?: \_\_\_\_\_  
Have you had a problem with infertility in the past?: Yes  No  If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
Have you taken any drugs for fertility in this pregnancy?: Yes  No  If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_



Have you had any of the following symptoms during this pregnancy that have been a significant problem for you?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Nausea: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue: _____
<input type="checkbox"/>	<input type="checkbox"/>	Burning with urination: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal or pelvic pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal discharge: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vulvar itching or irritation: _____
<input type="checkbox"/>	<input type="checkbox"/>	Sore breasts: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge or breast lump: _____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever or chills: _____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath: _____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeats: _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion, heartburn or abdominal pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools: _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression: _____
<input type="checkbox"/>	<input type="checkbox"/>	Change in a mole: _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in swallowing: _____
<input type="checkbox"/>	<input type="checkbox"/>	Leg or hand swelling: _____
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids: _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to rubella or other viral illnesses: _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any drugs: _____
<input type="checkbox"/>	<input type="checkbox"/>	Prescription drugs: _____
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drugs: _____

Have you had any X-rays or other radiation exposure during this pregnancy?: Yes  No

If yes, please explain: \_\_\_\_\_

Vaccine History: Flu Shot Yes  No  When: \_\_\_\_\_  
Gardasil Yes  No  When: \_\_\_\_\_  
Tetanus Yes  No  When: \_\_\_\_\_

### **MEDICAL HISTORY**

Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (including nonprescription drugs)? If yes, give name of medication and time taken during pregnancy: \_\_\_\_\_

Are you allergic to any drugs?: Yes  No  What happened?: \_\_\_\_\_

Latex Allergy?: Yes  No

Have you had any of the following?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Serious accident or illness: _____
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic or hip fracture: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion: _____

Have you had any of the following problems?

Yes	No	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous or mental problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression _____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety _____
<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic complications: _____
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection: _____
<input type="checkbox"/>	<input type="checkbox"/>	German measles: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures: _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches: _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure: _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast abnormalities: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones: _____
<input type="checkbox"/>	<input type="checkbox"/>	Deep venous thrombosis (blood clots in your legs): _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding abnormalities: _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis: _____

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### HABITS

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	When was the last time you had a cigarette? _____ How many packs do you smoke a day? _____ How old were you when you started smoking? _____
<input type="checkbox"/>	<input type="checkbox"/>	When was the last time you had a drink of alcohol? _____ What is the average number of drinks per week? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used street drugs? _____ Marijuana, cocaine, crank? Have you ever put drugs in your veins? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your partner a heavy drinker? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt you ought to cut down on your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have people annoyed you by criticizing your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt bad or guilty about your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener)
<input type="checkbox"/>	<input type="checkbox"/>	Do you use seatbelts? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly? _____

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### SOCIAL HISTORY

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are there any family or social problems you feel I should know about? Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your partner supportive of your pregnancy? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does he plan to be present with you at your baby's birth? _____

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### FAMILY HISTORY

Do any of the following diseases/conditions run in your family?

Yes	No	If yes, please describe type and relative involved:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis: _____

**FAMILY HISTORY** (cont.)

- Do any of your relatives have Down's Syndrome or any other chromosomal abnormalities that you know of?
- Are there any twins in your family?
- Does any member of your extended family have a cleft lip or palate, pyloric stenosis, congenital heart disease, neural tube defects (Spina Bifida or other types), clubbed feet, Cystic Fibrosis, PKU, Muscular Dystrophy, Hemophilia or any other known birth defects or abnormalities?
- Did any of your relatives require surgery in the first year of life?  
If yes, please describe: \_\_\_\_\_
- Is there a family history of mental delays or deficits?
- If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
- If you or the baby's father are black, have either of you been screened for sickle cell trait?
- If you or the baby's father are Italian, Greek or Mediterranean background, have either of you been tested for  $\beta$ -thalassemia?
- If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for  $\alpha$ -thalassemia?

**PAST PREGNANCIES:**

1. Please describe all your prior pregnancies, including date, live birth (yes or no), sex of child, name of child, weight of child, hospital where child was born, method of delivery (C-section or vaginal) any pre-term labor with the pregnancy and any complications during pregnancy, labor or delivery.

	First	Second	Third	Fourth	Fifth
Date					
Live birth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>
Name					
Weight					
Gestational Age					
Epidural					
Any complications during pregnancy, labor or delivery (please describe)					

(If more than five pregnancies, please complete on separate sheet)

Who is going to be your baby's doctor?: Pediatrician \_\_\_\_\_ Family doctor \_\_\_\_\_

Are you going to: Breast feed?  Bottle feed?

Is there anything about your prior pregnancy (or pregnancies), labor or delivery experiences you would or would not want repeated?: (please explain) \_\_\_\_\_

Is there anything else you feel your doctor should know about you, your partner or your family? \_\_\_\_\_