Indiana University Health

Prenatal Diagnosis Clinic

Patient Label

AMBULATORY REGISTRATION FORM

PLEASE BE SURE TO BRING ALL INSURANCE CARDS AND A PHOTO ID WITH YOU FOR YOUR APPOINTMENT

PATIENT DEMOGRAPHIC INFORMATION:

Legal Name: _____ Birthdate: _____/_____/_____

SS#: _____-_____-_____ Race: _____ Gender:_____ Marital Status: _____

Address: _____ City: _____ State: _____Zip: _____

County of Residence: _____ Country: _____ Primary Language: _____

Primary Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Primary Care Doctor: _____ Referring Doctor: _____

Employment Status: (circle one) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty

Employer Name: _____ Employer Phone: (_____) _____-_____

NEXT OF KIN: ***(Emergency Contact Person Information)***

Patient Relationship to NOK: _____ Birthdate: _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Phone: (____) _____-_____ Work: (_____) _____-_____ Alternate: (_____) _____-_____

ALTERNATIVE CONTACT INFORMATION:

Patient Relationship to Contact Person: _____ Birthdate: _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Phone: (_____) _____-_____ Work: (_____) _____-_____ Alternate: (_____) _____-_____

You have been scheduled for genetic counseling in our clinic. Please take a moment to provide the following information so that we can better serve your healthcare needs:

Why have you been referred to Prenatal Diagnosis: _____

Have you or a family member ever seen a genetic counselor or geneticist before? Y or N

If yes, for what reason? _____

Please list any MEDICATIONS you are currently taking (prescription, over the counter, herbal, vitamin supplements, etc…) **if pregnant include all medications taken at any point since your last period*

_____

Please list any EXPOSURES during the pregnancy (alcohol, tobacco, x-rays, etc…)

_____

Please list any health problems you have (e.g. diabetes, high blood pressure, infertility, etc…):

_____

PERSONAL DATA (PATIENT)

Age at the time of delivery:_____ Occupation: _____

Highest level of education (High School, College, MS, Ph D…): _____

PERSONAL DATA (SPOUSE/PARTNER)

Name: _____ Age: _____ Birthdate: _____ Occupation: _____

Highest level of education (High School, College, MS, Ph D…): _____

PREGNANCY HISTORY

How many total pregnancies have you had? (*Include current pregnancy if applicable*) _____

First date of your last period: _____ Estimated due date (if known): _____

For each living child, please complete the following:

Child's full name:	Gender:	Birthdate:	Any health or developmental concerns:
	M or F	/ /	
	M or F	/ /	
	M or F	/ /	

If you had a child that has died, please complete the following:

Child's name:	Gender:	Birthdate:	Age at Death:	Cause of death: (if known)
	M or F	/ /		
	M or F	/ /		

For any pregnancy loss: miscarriage (MIS), stillbirth (SB), or elective abortion (EAB):

Type of loss (circle)	Month/Year	How far along:	Cause of loss: (if known)
MIS SB EAB			
MIS SB EAB			
MIS SB EAB			

If your partner has any other children in addition to your own, please provide their full names, birthdates, and any health or developmental concerns:

1._____
2._____
3._____

FAMILY HISTORY

Do you or your partner have one or more relatives with any of the following conditions?

Condition	Your side	Father's side	How is this person related to you?
Neural tube defect (e.g. spina bifida)			
Heart problem at birth			
Cleft lip or cleft palate			
Other birth defects (please describe)			
Bleeding problems (e.g. hemophilia)			
Muscle problems (e.g. Muscular Dystrophy)			
Early vision/hearing loss or neurological problems (e.g.Huntington disease)			
Cystic fibrosis, sickle cell anemia or other hereditary disease			
Chromosome disorder (e.g. Down syndrome)			
Developmental delay, intellectual disability, or autism			
Infant death, stillbirth, or three or more pregnancy losses			
Other conditions that concern you (please describe)			