

## Patient Information & Pregnancy Questionnaire

Name (First): \_\_\_\_\_ (Last): \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County (CA only): \_\_\_\_\_

Contact Info: Home #: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**PARTNER INFORMATION (if the patient is pregnant, then “partner” is the father of the pregnancy)**

Name (First): \_\_\_\_\_ (Last): \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_\_ Occupation: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

**PREGNANCY AND EXPOSURE INFORMATION**

Are you currently pregnant?  NO  YES **Due date:** \_\_\_\_\_

Have you taken any medications during this pregnancy (besides prenatal vitamins or Tylenol)?  NO  YES

If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_

**Since becoming pregnant, have you had any:**

(or if not pregnant please check current exposures)

Recreational Drugs  NO  YES \_\_\_\_\_

Cigarettes  NO  YES \_\_\_\_\_

Alcohol  NO  YES \_\_\_\_\_

Fevers  NO  YES \_\_\_\_\_

X-rays  NO  YES \_\_\_\_\_

**Do you have any of the following conditions?**

Diabetes?  NO  YES \_\_\_\_\_

A seizure disorder?  NO  YES \_\_\_\_\_

**CONFIDENTIAL or PRIVATE MESSAGES:**

Integrated Genetics/Esoterix Genetic Laboratories, LLC has my permission to leave detailed messages about **confidential medical information and test results** at the number(s) noted below.  YES  NO (if no, proceed to the signature box)

Preferred confidential phone number:  Home  Cell  Work  Other: \_\_\_\_\_

Who else can we leave test results with? \_\_\_\_\_ Phone: \_\_\_\_\_

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_