



# CHICAGO MATERNAL-FETAL MEDICINE, S.C.

2507 NORTH HALSTED STREET

CHICAGO, IL 60614

TELEPHONE (773) 348-8032

FAX (773) 348-8042

## PATIENT INFORMATION

PATIENT NAME		SOCIAL SECURITY		DATE OF BIRTH	
ADDRESS		CITY	STATE	ZIP CODE	
HOME PHONE	CELL PHONE	E-MAIL			
EMPLOYED BY:			WORK PHONE		
EMPLOYERS ADDRESS		CITY	STATE	ZIP CODE	
NAME OF HUSBAND/FATHER		DATE OF BIRTH	SOCIAL SECURITY		
ADDRESS IF DIFFERENT FROM ABOVE		CITY	STATE	ZIP CODE	
HOME PHONE	CELL PHONE	E-MAIL			
EMPLOYED BY:			WORK PHONE		
EMPLOYERS ADDRESS		CITY	STATE	ZIP CODE	
WHO SHOULD WE NOTIFY IN THE EVENT OF HOSPITALIZATION?		RELATIONSHIP	PHONE:		

## MEDICAL HISTORY

MEDICAL PROBLEMS:

ARE YOU ALLERGIC TO ANY MEDICATION?

ARE YOU TAKING ANY MEDICATION(PRESCRIPTION OR NON-PRESCRIPTION)? IF YES PLEASE EXPLAIN:

HAVE YOU EVER HAD A BLOOD TRANSFUSION?

## RECORD OF PREGNANCIES

TOTAL NUMBER PREGNANCIES:		TOTAL # OF FULL-TERM DELIVERIES:		ANY MISCARRIGES		PREMATURE DELIVERIES:		
ABORTIONS:		ECTOPIC PREGNANCIES:		FIRST DAY OF YOUR LAST MENSTRAUL PERIOD:				
IF YOU HAVE HAD OTHER PREGNANCIES PLEASE FILL SECTION AS FOLLOWED								
MONTH/ DAY/ YEAR	# OF WEEKS AT TIME OF DELIVERY	BABY'S WEIGHT	HOSPITAL OF DELIVERY	CEASEREAN OR VAGINAL	ANY COMPLICATIONS		HAS BABY SURVIVED BOY/GIRL	
				C V	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
				C V	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
				C V	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
				C V	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
				C V	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

## WHO SHOULD WE THANK FOR REFERRING YOU

NAME OF REFERRING PHYSICIAN OR OTHER			PHONE:		
ADDRESS		CITY	STATE	ZIP CODE	