1PAND

Patient Information:
Name (last, first, middle initial): ______________________ Email Address: ______________________

Address: ______________________ Apt # ______ City: ______________ State: ______ Zip Code: ________

Date of Birth: ______________ Age: ____ Sex: ☐ Male ☐ Female Social Security Number: ______________ Preferred Language: ____________

Phone Number (mobile): ______________________ Phone Number (alternate): ______________________ ☐ home ☐ work

To minimize disruption to your daily life but also keep you informed, Inova uses SMS text message to communicate non-clinical messages like appointment reminders and surveys. If you would prefer that we contact you via another method, please let us know.

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired Employer: ______________________
☐ Student ☐ Other ______________________

Emergency Contact: ______________________ Relationship to Patient: ______________________

Address: ____

Phone Number (home): ______________________ Phone Number (alternate): ______________________ ☐ cell ☐ work

Demographics: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ More than one race ☐ Hispanic ☐ Native Hawaiian or other Pacific Islander
☐ Decline to say ☐ Other ______________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to say

Insurance Information – We will request to scan your ID and insurance card.
Primary Insurance: ______________________ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No
Member ID # ______________________ Provider/Insurance Services Phone Number ______________________
Secondary Insurance: ______________________ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No
Member ID # ______________________ Provider/Insurance Services Phone Number ______________________

Insured Information (if other than patient):
Subscriber/Policy Holder: ______________________ Relationship to Patient: ______________________
Address: ____
Social Security Number: ______________ Date of Birth: ______________ Subscriber Employer: ______________

Please indicate your referring provider in addition to other providers who will need your treatment information.

Primary Care Provider Name: ______________________

Address: ______________________ Phone Number: ______________ Fax Number: ______________

Specialty Care Provider Name: ______________________ Specialty: ______________________

Address: ______________________ Phone Number: ______________ Fax Number: ______________

Specialty Care Provider Name: ______________________ Specialty: ______________________

Address: ______________________ Phone Number: ______________ Fax Number: ______________

Patient/Parent/Guardian (signature): ______________________ Date: ____________ Time: ____________

Patient/Parent/Guardian (print name): ______________________ Relationship: ______________

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ______________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________

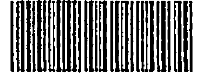
Date of Birth: ______________ Medical Record # ______________

Gender: ☐ Male ☐ Female

Inova Medical Group
Patient Registration Form

IMG Location: ______________________

CAT # 20806DT/R050620 • PKGS OF 100



1PROD

The Health Insurance Portability and Accountability Act (HIPAA) **Privacy Rule** gives you the right to request how and where your healthcare provider communicates with you. We invite you to share your preferred place and manner of communication. You may change, update or revoke this information at any time, though it must be done in person. The information on this form will remain in effect for one year. You may revoke it at any time.

Print Name:_______________________ **Date of Birth:** ____________

I prefer to be contacted in the following manner (check all that apply):

☐ **Patient Portal:** MyChart
☐ **Phone Contact:** Use the following numbers to contact me:

Home Phone: ____________ ☐ Leave message with detailed information ☐ Leave message with a call back number only

Cell Phone: ____________ ☐ Leave message with detailed information ☐ Leave message with a call back number only

Work Phone: ____________ ☐ Leave message with detailed information ☐ Leave message with a call back number only

☐ **Written Communication:** ☐ Mail to my home address ☐ Other: ____________

☐ **Other:** ____________________________

Preferred Contacts:

We respect your right to indicate who you prefer to involve in your treatment decisions and/or with whom your information is shared. Please note, however, that we may also share your information as set forth in our Notice of Privacy Practices.

Please indicate the person (s) you prefer we share your information with below:

Name: ____________ Phone: ____________ Relationship: ____________

Name: ____________ Phone: ____________ Relationship: ____________

Name: ____________ Phone: ____________ Relationship: ____________

Patient (signature): ____________ Date: ________ Time: ________

Patient (print name): ____________

Parent or Guardian (if patient is a minor or otherwise not competent):

(signature): ____________ Date: ________ Time: ________

(print name): ____________ Relation to Patient: ____________

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ____________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________

Date of Birth: ________ Medical Record # ________

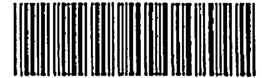
Gender: ☐ Male ☐ Female

Inova Medical Group

Patient Record of Disclosure-Preferred Contacts

☐ Specialty (location): ____________
☐ Primary (location): ____________

CAT # 20749DT/R013020 • PKGS OF 50


1PMTREV

Department/Location: ____________________

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:
I understand and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
- **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Inova, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Inova.** I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. *I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient or physician office visits to Inova, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Inova.

Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

Relationship to Patient (if not signed by patient)

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ____________________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

Inova
Authorization for Claims, Payment, and Reviews - Ambulatory

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: ____________ ☐ Other: ____________

CAT # 20083DT/R050420 • PKGS OF 25

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.** I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE ________ DATE ________ TIME ________

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE ________

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY ________

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ________

Date of Birth: ________ Medical Record # ________

Gender: ☐ Male ☐ Female

Inova Health

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R081015
PKGS OF 100

Inova Staff:
1. **If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.**
2. **A new form should be used at every visit and any time a change in accommodations is requested.**

Name of Person Requesting/Declining Accommodations: ____________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other ____________

Do you and/or your companions have any special needs that require accommodations? ☐ **YES (complete boxes A and B)** ☐ **NO (complete box B)**

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing:
☐ Sign language interpreter ☐ Notepad and pen ☐ Speak loudly
☐ Sound amplifier (ex. PockeTalker® or disposable Posey®)
☐ Uses hearing aid(s): ☐ Left ☐ Right ☐ Bilateral
☐ Amplified phone with flasher (if admitted)
☐ Video Remote Interpreter (VRI) (where available)
☐ Other: ____________

Vision:
☐ Magnifying sheet ☐ Request an escort
☐ Braille phone ☐ Documents read out loud
☐ Other: ____________

Mobility:
☐ Uses service animal ☐ Walking escort
☐ Wheelchair escort ☐ Extra-wide wheelchair escort
☐ Accessible exam table ☐ Accessible weight scale
☐ Other: ____________

Speech:
☐ Point-to-Speak cards ☐ Point-to-Speak alphabet ☐ Notepad and pen
☐ Other: ____________

Other or Special Instructions: ____________

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

☐ Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature) | **Patient/Representative/Companion** (print name) | Date | Time

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other: ____________

Staff Witness (signature) | **Staff Witness** (print name) | Date | Time | Contact # | Department

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID# (if applicable) ____________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

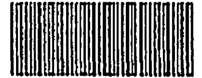
Inova

Americans with Disabilities Act (ADA)/ Special Needs Assessment

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: ________ ☐ Other: ________

CAT # 20328DT/R022420 • PKGS OF 50

INOVA



Date of Visit: ________________
Reason for Visit: ________________
Allergies: ________________

Past Medical History (list all prior medical diagnoses)

________________ ________________
________________ ________________
________________ ________________

Past Surgical History (list all surgeries and dates)

Surgery	Date	Surgery	Date

Significant Medical Conditions in Your Family

Condition	Family Member	Condition	Family Member

Medications (include over-the-counter medications)

Medication	Dose	Frequency

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? ________
Do you vape? ☐ Yes ☐ No Do you use smokeless tobacco (ex. chew, snuff)? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ________
Do you currently or have you ever used illicit drugs? ☐ Yes ☐ No If yes, please list: ________
Do you exercise? ☐ Yes ☐ No If yes, how often? ________

Age at first menstrual period:	First day of last menstrual period:
Number of days between menstrual periods:	Number of days menstrual period lasts:
Are you having any menstrual problems? ☐ Yes ☐ No If yes, describe:	
Are your periods: ☐ Regular ☐ Irregular	**Number of pads or tampons/day:**
Flow: ☐ Light ☐ Moderate ☐ Heavy	**Cramps:** ☐ Mild ☐ Moderate ☐ Severe

Are you menopausal? ☐ Yes ☐ No If yes, age at which you started menopause: ________
If you are menopausal, are you having any vaginal bleeding? ☐ Yes ☐ No If yes, describe: ________
When was your last Pap Test? ________ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal Pap Test? ☐ Yes ☐ No If yes, when? ________

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ________________

Date of Birth: ________ Medical Record # ________

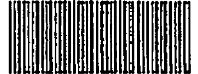
Gender: ☐ Male ☐ Female

Inova Medical Group
OB/GYN
Medical Condition & History

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

CAT # 20857DT/R030420 • PKGS OF 50

INOVA



2PSMHX

Date of last: Mammogram: ____________ DEXA (bone density scan): ____________

Colonoscopy: ____________ Tdap/Tetanus vaccine: ____________

Have you received the Human Papillomavirus (HPV) vaccine? ☐ Yes ☐ No

What type(s) of birth control have you used in the past? ☐ Intrauterine Device (IUD) ☐ Oral Contraceptives ☐ Depo Provera ☐ Other ____________

Current Contraception: ____________ Do your partners use condoms? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No Are your partners: ☐ Male ☐ Female ☐ Both

Number of sexual partners over your lifetime: _______ Number of times you have sex per month: _______

Do you want to be tested for sexually transmitted diseases (STDs)? ☐ Yes ☐ No

Have you ever had an sexually transmitted disease (STD)? ☐ Yes ☐ No

If yes, check any of the STDs which you have had: ☐ Chlamydia ☐ Gonorrhea ☐ Venereal Warts ☐ Genital Herpes ☐ HPV ☐ Human Immunodeficiency Virus (HIV) ☐ Other: ____________

Pregnancies

Pregnancy Date	Type of Delivery (vaginal or c-section)	Complications	Pregnancy Dates	Type of Delivery (vaginal or c-section)	Complications

Number of:	Miscarriages:	Terminations:	Living Children:

Current Medical Conditions (please check all that you are currently experiencing):

☐ Blood in stool
☐ Blood in urine
☐ Breast pain
☐ Chest pain
☐ Constipation
☐ Cough
☐ Decreased sexual drive
☐ Diarrhea
☐ Difficulty concentrating
☐ Dizzy spells/fainting
☐ Domestic violence
☐ Excess body/facial hair
☐ Fever
☐ Frequent bruising
☐ Hair loss
☐ Headaches
☐ Heartburn/indigestion
☐ Heat/cold intolerance
☐ Hot flashes/night sweats
☐ Irregular heartbeat
☐ Nausea
☐ Pain or bleeding with sex
☐ Pelvic pain
☐ Premenstrual symptoms
☐ Severe joint/muscle pain
☐ Skin lesions
☐ Trouble breathing
☐ Trouble sleeping
☐ Trouble with balance
☐ Unexplained weight change
☐ Unusual fatigue
☐ Urination-frequency increase
☐ Urination-incontinence
☐ Urination-pain
☐ Vaginal discharge/odor
☐ Vaginal dryness
☐ Vulvar itching/rash
☐ Victim of sexual abuse
☐ Vomiting
☐ Other: ____________
____

☐ Check here if more space is needed. Continue on back of page.

My signature verifies that the information provided is correct to the best of my knowledge.

____________ ____________ ____________

Patient or Designated Decision Maker (signature) Date Time

____________ ____________

If Designated Decision Maker (print name) Relationship

Reviewed by Physician (signature): ____________ Date: ____________ Time: ____________

Physician (print name): ____________

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ____________
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ____________

Date of Birth: ____________ Medical Record # ____________

Gender: ☐ Male ☐ Female

Inova Medical Group

OB/GYN

Medical Condition & History

CAT # 20857DT/R030420 • PKGS OF 50

Prenatal Questionnaire

NAME:______________________________ **Date of Birth**______________

Do you have any allergies? If so what is the reaction you experience?:

Current Medications: Dose/route/frequency (include prescriptions, vitamins and over the counter medications)

Preferred Pharmacy: (Name, Street, City, State)

Height: ________________ **Weight prior to pregnancy:** ________________

Medical History:

	YES	NO		YES	NO		YES	NO
Abnormal Pap			Diabetes			Infertility		
Anemia			Endometriosis			IBS		
Anxiety			Gall bladder disease			Multiple Sclerosis		
Asthma			Gestational Diabetes			Seizures		
Blood clotting disorder			Headaches			STDs		
Blood transfusion			Hemorrhoids			Toxoplasmosis		
Breast problems			Herpes			Tuberculosis		
Coronary Artery Disease			Hypertension			Uterine abnormalities		
Crohn's Disease			Hyperthyroid			UTI		
Depression			Hypothyroid			Varicella/Chicken pox		

Other:

Surgical History

	YES	NO		YES	NO
Appendectomy			Cryosurgery of cervix		
Breast biopsy			D&C		
Breast enhancement			Hysterectomy		
Breast Reduction			Hysteroscopy		
C-Section			Laser ablation of cervix		
Cholecystectomy			Leep		
Colposcopy			Pelvic laparoscopy		
Conization of cervix			Tubal ligation		

Other:

Family Medical History

	Status (alive/deceased)	Alcohol Abuse	Alzheimer's	Bipolar disorder	Breast cancer	Colon Cancer	Heart disease	Depression	Early menopause	Gall bladder disease	High cholesterol	Hypertension	Hyperthyroid	Hypothyroid	Melanoma	Migraines	Osteoporosis	Ovarian Cancer	Stroke	Uterine Cancer
Mother																				
Father																				
Brother																				
Sister																				
MGM																				
MGF																				
PGM																				
PGF																				

Other: ______________________________

SOCIAL HISTORY:

Have you ever smoked? ❑Yes ❑No ❑Current smoker ❑Quit (month/year): __________

If yes, how many packs per day? ❑<1 ❑1 ❑2 ❑>3

For how many years?__________

Do you drink alcohol? ❑Yes ❑No

If yes, how many drinks per week? ❑<1 ❑1-4 ❑5-10 ❑>20

Have you ever used recreational drugs, including prescription drugs? ❑Yes ❑No

If yes, what drug(s)__________

Are you sexually active?__________

Type of partner ❑ Male ❑ Female ❑ Both

Number of partners __________

Method of birth control prior to pregnancy: __________

PSYCHOSOCIAL HISTORY

Who lives at home with you? __________

Highest level of education:

❑Elementary ❑Junior High ❑High School ❑College ❑Graduate School

What is your occupation? __________

Marital status:
❑Single ❑Partnered/Married ❑Divorced ❑Widowed ❑Other

If you have a domestic partner/spouse, what is his or her name? ____________________

If you have a partner, has he or she ever hit you, kicked you or threatened to harm you?
❑Yes ❑No

OBSTETRIC HISTORY:

Pregnancies: _____ # Deliveries: ____ # Abortions: ____ # Miscarriages: ____ # Ectopic Pregnancies: _____

Pregnancies: (outcome is vaginal delivery, cesarean, miscarriage, abortion or ectopic)

	Date	Outcome	# of weeks	Is baby living	Hours in Labor	Weight of Baby	Sex	Name of Baby	Hospital	M.D.	Epidural
1											
2											
3											
4											
5											

Did you have pre-term labor with any of your prior pregnancies?
❑Yes ❑No
Did you have any complications during any of your previous pregnancies? *Diabetes, hypertension, anemia, preterm delivery. Please specify*
❑Yes ❑No
Did you have any complications during your previous deliveries? *Excessive bleeding, shoulder dystocia, please specify*
❑Yes ❑No
Did any of your babies weigh more than 9 lbs or less than 5.5 lbs?
❑Yes ❑No
Did your baby require stay in the Neonatal Intensive Care Unit?
❑Yes ❑No
Did you breastfeed with your other babies? If so, for how long?
❑Yes ❑No

MENSTRUAL HISTORY:

First day of most recent period: **(LMP)** ___________ Are your periods regular? ❑ Yes ❑ No
Age at onset of menses: ___________ Length of Cycles: ________ days (start to start)
Days of bleeding: __________
Flow: ❑Light ❑Medium ❑Heavy Pain or cramps? ❑Yes ❑No

CURRENT PREGNANCY

Did you have fertility treatment with this pregnancy? ❑Yes ❑No

If so what type? ______________________

If you took fertility medications, which one(s) did you take? ______________

Are you experiencing any of the following?

- Nausea or vomiting ❑Yes ❑No
  If you are throwing up, on average how many times a day?
- Vaginal bleeding ❑Yes ❑No
- Cramping ❑Yes ❑No
- Constipation ❑Yes ❑No

Do you plan on breastfeeding?

❑Yes ❑No

If you breast fed with your prior children, for how long? ______________

INFECTION SCREENING:

Do you live with someone with TB or have you been exposed to TB?

❑Yes ❑No ❑Don't Know

Do you or your partner have genital herpes?

❑Yes ❑No ❑Don't Know

Have you had Gonorrhea, Chlamydia, HPV, Syphilis or Trichomoniasis?

❑Yes ❑No ❑Don't Know

Have you had the chicken pox or varicella vaccine?

❑Yes ❑No ❑Don't Know

Do you have cats?

❑Yes ❑No

Have you or your partner traveled out of the country or to a Zika-affected area in the past 12 weeks? If so to where?

❑Yes ❑No Location ______________

HEALTH CARE MAINTENANCE

Last Pap smear (month/year): __________ ❑ Normal ❑ Abnormal

Did you have a flu shot this flu season? (September-March) ❑Yes ❑No

PRENATAL GENETIC SCREENING:

Mother of Baby is your ancestry:
❑ Caucasian/Northern European descent ❑African American ❑Jewish
❑Italian, Greek, Middle Eastern ❑Asian ❑Hispanic ❑Filipino ❑Other________

Father of Baby is his ancestry:
❑ Caucasian/Northern European descent ❑African American ❑Jewish
❑Italian, Greek, Middle Eastern ❑Asian ❑Hispanic ❑Filipino ❑Other ________

Will you be 35 years old or older when the baby is due? _______________

Do you, the baby's father or anyone in either family have any one of the following disorders:

- Thalasemia.. ❑Yes ❑No
- Neural Tube Defect, Spina Bifada Anencephaly .... ❑Yes ❑No
- Congenital Heart Defect .... ❑Yes ❑No
- Down Syndrome .... ❑Yes ❑No
- Tay-Sachs.. ❑Yes ❑No
- Sickle Cell Disease or Trait .... ❑Yes ❑No
- Hemophilia or Blood Disorder .... ❑Yes ❑No
- Muscular Dystrophy .... ❑Yes ❑No
- Cystic Fibrosis .... ❑Yes ❑No
- Mental Retardation/Autism.. ❑Yes ❑No
- Spinal Muscular Atrophy.. ❑Yes ❑No
- Any other Genetic or Chromosomal Disorder .... ❑Yes ❑No

Do you, the baby's father or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above? ❑Yes ❑No ❑Don't Know

Are you and the father of the baby blood relatives? ❑Yes ❑No

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby's father:

Print Name_________________________________ Date of Birth_____________

Signature__________________________________ Date___________________