Integrated GENETICS
LabCorp Specialty Testing Group

PATIENT INFORMATION & PREGNANCY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y):_____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____ County (CA only): _____ Occupation: _____

PARTNER INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y):_____ Age: _____

Occupation: _____ Is your partner the biological father of the pregnancy? ☐NO ☐YES

If no, did you use a sperm donor? ☐NO ☐YES

PATIENT CONTACT INFORMATION AND AUTHORIZATION

Cell: _____ Home: _____ Work: _____

May we leave a detailed voice message that includes **confidential medical information and test results**? ☐YES ☐NO

If YES, check all that apply: ☐Cell ☐Home ☐Work

If we are unable to reach you, is there another person with whom we can leave a detailed voice message that includes **confidential medical information and test results**: ☐NO ☐YES If YES, complete below:

Name: _____Relationship:_____Number: _____

●Patient has the right to revoke permission for the confidential voice mail ●Patient assumes responsibility for information left on the confidential voice mail

REFERRING DOCTOR (PRIMARY OB/GYN) OR CLINIC INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

PREGNANCY AND EXPOSURE INFORMATION

Do you have or have you ever had any of the following?

Diabetes? ☐NO ☐YES
Seizure disorder? ☐NO ☐YES
Lupus? ☐NO ☐YES
Graves' disease or Hashimoto Thyroiditis or thyroid cancer? ☐NO ☐YES

Are you currently pregnant? ☐NO ☐YES

Due date: _____

Are you or the biological father of the pregnancy adopted?
☐NO ☐YES If yes, please specify: _____

Do you take any medications on a regular basis? ☐NO ☐YES
If yes, please specify. If you are pregnant, please list any medications you have taken since conception (other than prenatal vitamins and Tylenol): _____

_____

_____

Since becoming pregnant, have you had any:

Cigarettes ☐NO ☐YES _____
Alcohol ☐NO ☐YES _____
Recreational Drugs ☐NO ☐YES _____
Fevers (greater than 101˚ F) ☐NO ☐YES _____
X-rays (other than dental) ☐NO ☐YES _____

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

PATIENT SIGNATURE: _____ **DATE:** _____