labcorp

PATIENT INFORMATION & PREGNANCY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: ______________________ First: ______________________ Preferred Name: ______________________

Birth date (M/D/Y):__________________ Age: _________ Occupation: ______________________________

Sex assigned at birth: ☐ Female ☐Male ☐_________________________ Gender identity (optional): ______________
(Explain if needed)

Address: ____ City: ______________________________

State: ______________________ Zip: ________County (CA only): ____________________________________

PARTNER INFORMATION

Last Name: ______________________ First: ______________________ Preferred Name: ______________________

Birth date (M/D/Y):__________________ Age: _________ Occupation: ______________________________

Sex assigned at birth: ☐ Female ☐Male ☐_________________________ Gender identity (optional): ______________
(Explain if needed)

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 taken since conception (other than prenatal vitamins and Tylenol): ______________________________

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Since becoming pregnant, have you had any:

Fevers (greater than 101˚ F) ☐NO ☐YES ______________
X-rays (other than dental) ☐NO ☐YES ______________
Cigarettes ☐NO ☐YES ______________
Alcohol ☐NO ☐YES ______________
Other substance use (including medical cannabis) ☐NO ☐YES ______________

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

PATIENT SIGNATURE: ____ **DATE:** ______________

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