

Sara Thyr N.D., LLC
 222 River Road
 Manchester, NH 03104
 603-624-5605
 www.DrThyr.com

Client Registration

Name First Middle Last				Date		Phone (Work) Home	
Maiden		Race		Religion		Yrs Educ	
Marital Status		Occupation/Type of Business		Date of Birth		State of Birth	
Address: Street City Zip				Inside City limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		How long at this address?	
Father of Baby: First Middle Last				Race		Yrs Educ	
Date of Birth				State of Birth			
Address (if different from above)				Phone (Work, Home)		Occupation/Type of Business	
Partner/Husband (if different from father)				Another person to contact in case of emergency Name: Relationship: Phone:			
Method of Payment: <input type="checkbox"/> Medicaid <input type="checkbox"/> Cash <input type="checkbox"/> Other:				Insurance Information: Copay _____ Name of Policy Holder: _____ Policy # _____ Group # _____			
Social Security Number (SSN)		Father's SSN		SSN requested for baby <input type="checkbox"/> Yes <input type="checkbox"/> No		Referred by:	

Please answer the following questions which will help determine if there are potential problems which should be discussed further. This information is completely confidential.

FAMILY HISTORY – Intake if anyone in your immediate family has ever had any of these, who, when.

- High blood pressure _____
- Cancer _____
- Diabetes _____
- Twins _____
- Severe emotional problems _____
- Alcohol/drug abuse _____
- Other _____

FATHER OF BABY – Indicate if the baby's father has ever had any of these; when.

- Sexually transmitted diseases _____
- Herpes: Genital Oral _____
- Severe emotional problems _____
- Alcohol/drug abuse _____
- Tobacco use _____
- Other _____

YOUR MOTHER'S HISTORY – Please answer the following regarding your mother:

- No. of pregnancies _____
- No. of births _____
- Miscarriages _____
- Any complications _____
- Your weight at birth _____
- Did she take DES with you?
 Yes No

PREVIOUS PREGNANCY OUTCOMES <i>Please complete this table regarding your own pregnancies (from earliest to most recent)</i>			
Date	# Weeks	Birth/Miscarriage/Termination	Comments/Problems

- Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
- Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?
- Yes No Are you and the FOB related by blood? (e.g. cousins)
- Yes No Are you or the FOB from any of these ethnic/racial groups (circle)
Jewish Black/African Asian Mediterranean
- Yes No Have you or the FOB ever had hepatitis or jaundice?
- Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?
- Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
- Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
- Yes No Do you think you are at increased risk for AIDS/HIV?
- Yes No Have you ever experienced dramatic fluctuations in your weight?
- Yes No Have you ever had anorexia, bulimia, or other eating problems?
- Yes No Is there anything about the development of your sexuality that you'd like to discuss?
- Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
- Yes No Have you ever had severe emotional problems?
- Yes No Have you ever been on any medication for psychological problems?
- Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

NAME _____

MEDICAL HISTORY Please indicate if you have ever had any of these; when:

- | | |
|--|---|
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Bowel Problems/colitis |
| <input type="checkbox"/> Eye/vision problems | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Ear/hearing problems | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary surgery |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Urethral dilation |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Aching joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pelvic/back injuries |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Other |

Do you have any allergies? Yes No
Please list: _____

GYNECOLOGICAL HISTORY

Age at first period _____ When was your last Pap smear? _____
Cycle length (days) _____
Regular? Yes No Have you ever had an abnormal Pap? (dates) _____
Duration _____ Please describe _____

Please indicate if you have ever had any of the following; when:

- | | |
|---|--|
| <input type="checkbox"/> Yeast _____ | <input type="checkbox"/> Cervicitis _____ |
| <input type="checkbox"/> Trichomonas _____ | <input type="checkbox"/> Cervical surgery _____ |
| <input type="checkbox"/> Group B Strept _____ | <input type="checkbox"/> Cervical polyp _____ |
| <input type="checkbox"/> Bacterial vaginosis _____ | <input type="checkbox"/> Ovarian cyst _____ |
| <input type="checkbox"/> Chlamydia _____ | <input type="checkbox"/> Fibroids _____ |
| <input type="checkbox"/> Gonorrhea _____ | <input type="checkbox"/> Endometriosis _____ |
| <input type="checkbox"/> Syphilis _____ | <input type="checkbox"/> Abnormal bleeding _____ |
| <input type="checkbox"/> PID/Pelvic infection _____ | <input type="checkbox"/> Uterine surgery _____ |
| <input type="checkbox"/> Genital sores _____ | <input type="checkbox"/> Breast lump(s) _____ |
| <input type="checkbox"/> Herpes: <input type="checkbox"/> Genital | <input type="checkbox"/> Breast surgery _____ |
| <input type="checkbox"/> <input type="checkbox"/> Oral | <input type="checkbox"/> Infertility _____ |
| <input type="checkbox"/> Condylomata (warts) _____ | <input type="checkbox"/> Other _____ |

Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you'd like to discuss?

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? Yes No
Suspected date of conception _____
Pregnancy test (date) _____
Planned pregnancy? Yes No
Feelings about pregnancy _____
Father's/Partner's feelings _____
Most recent birth control used _____
Contraception used in past; what, when, any problems?

Please indicate if you've had any of the following problems during this pregnancy:

- | | |
|---|---|
| <input type="checkbox"/> Nausea _____ | <input type="checkbox"/> Urinary complaints _____ |
| <input type="checkbox"/> Vomiting _____ | <input type="checkbox"/> Abdominal/pelvic pain _____ |
| <input type="checkbox"/> Fever _____ | <input type="checkbox"/> Vaginal bleeding/spotting _____ |
| <input type="checkbox"/> Infections _____ | <input type="checkbox"/> Vaginal discharge _____ |
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Bleeding gums _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Varicose veins _____ |
| <input type="checkbox"/> Indigestion _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Leg cramps _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Rash _____ | <input type="checkbox"/> Loneliness _____ |
| <input type="checkbox"/> Backache _____ | <input type="checkbox"/> Family/relationship problems _____ |
| <input type="checkbox"/> Swelling _____ | <input type="checkbox"/> Work problems _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diarrhea _____ | |

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

- | | |
|--|--|
| <input type="checkbox"/> Tobacco _____ | <input type="checkbox"/> Herbs _____ |
| <input type="checkbox"/> Alcohol _____ | <input type="checkbox"/> Fumes/sprays _____ |
| <input type="checkbox"/> Caffeine _____ | <input type="checkbox"/> X-rays _____ |
| <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Ultrasound _____ |
| <input type="checkbox"/> Cocaine _____ | <input type="checkbox"/> Measles/Viruses _____ |
| <input type="checkbox"/> Street drugs _____ | <input type="checkbox"/> Travel _____ |
| <input type="checkbox"/> Other meds _____ | <input type="checkbox"/> Vaccinations _____ |
| <input type="checkbox"/> Non-pres. drugs _____ | <input type="checkbox"/> Cats _____ |
| <input type="checkbox"/> Vitamins _____ | <input type="checkbox"/> Other _____ |

Planned place of birth:

- Home Birth Center Hospital

If home, please indicate if you have:

- Water Electricity Telephone

Please use this space to add any other information regarding any of the above:

NAME _____