Medical Record Number

OB TRIAGE REGISTRATION FORM

Expected due date	Pre-pregnancy weight	Mother's height	Current weight

Patient's last name	First	Middle	Maiden name

Birth date	Age	Race	Patient's Social Security Number

State/country of birth	Your father's first name	Your mother's maiden name

Physical home address	Spouse's information, if married - fullname
City State ZIP	Date of birth / Age / Social Security Number
Mailing address (Fill out only if different from physical home address)	State/country of birth / Highest grade completed in school
Email	Race

Phone number	Cell number	County of residence	Highest grade completed in school

Emergency contact	Relation to contact
Emergency contact address	Emergency contact phone number

Please check the clinic where you receive your medical care.

- ☐ UK Women's Health OB-GYN
- ☐ UK Family & Community Medicine
- ☐ Central Baptist
- ☐ UK Midwives
- ☐ Polk-Dalton
- ☐ Referral

Your doctor:

Alcohol use YES ☐ NO ☐

If yes, number of drinks per week: ____________

Cigarette smoking YES ☐ NO ☐

If yes, please note number of cigarettes or packs/day

3 months before__________ Second 3 months ________

First 3 months__________ Last 3 months ________

Date pt. signed PN	Did you receive WIC during your pregnancy? ☐ YES ☐ NO	Planned pediatrician

Number of all Pregnancies (Don't forget to count this one)	Number of Deliveries	Number & Date of any Miscarriages or Abortions

Your Last Child's Birth Date	Date of Your Last Menstrual Period

Date of Your **First** Prenatal Visit	Date of Your **Last** Prenatal Visit	Approximate # of Prenatal Visits
List any Drug Allergies & Reaction	List any Food Allergies	Is this a Multiple Birth? Yes______No_______ How many?

The Information Below is to be Completed by the Clerk or Treatment Personnel Only

Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:

Print Form   Reset Form