Date of Visit:_____ **Type of Visit:** Pregnancy Test

First Name: _____**Last Name:** _____

Date of Birth: _____ **Age:** _____

Address: _____ **City:** _____ **Zip:** _____

Email: _____ **Phone #:** _____

May we reach out to via text or phone call? Yes / No

Race: (circle) Black / Caucasian / Pacific Islander / Asian / East Indian / Native American Mixed Race / Other

Pre-existing Medical Conditions: _____

Current Medications: _____

Any Medication Allergies: _____Reactions: _____

Other Allergies: _____

What Was the 1st Day of Your Last Menstrual Period: _____

Was It Normal? Yes / No **Are Your Periods Regular**? Yes / No

Are You Using Birth Control? Yes / No **Type of Birth Control**? _____

Total Number of Previous Pregnancies: _____ Live Births:_____ Miscarriage: _____ Abortion: _____

Early Pregnancy Symptoms: Nausea / Dizziness / Swollen, Tender Breasts / Fatigue

Do You Want to Be Pregnant? Yes / No / Undecided

Have You Been to Sac Valley Women's Health Before? Yes / No

How Did You Hear About Us? _____