



289 Summer Street  
Buffalo, New York 14222  
(716) 885-2229  
Fax: (716) 464-3361

NAME \_\_\_\_\_ TODAYS DATE \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

### HISTORY

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
FIRST DAY OF LAST MENSTRUAL CYCLE \_\_\_\_\_ EXPECTED DUE DATE \_\_\_\_\_  
HOW WERE YOU REFERRED TO MIDWIFERY SERVICES? \_\_\_\_\_  
PLACE OF EMPLOYMENT / OCCUPATION \_\_\_\_\_  
LAST GRADE OF HIGH SCHOOL COMPLETED \_\_\_\_\_  
POST-SECONDARY FORMAL EDUCATION (YEARS) \_\_\_\_\_  
RACE/ETHNIC ORIGIN     CAUCASIAN     AFRICAN/CARIBBEAN     NATIVE AMERICAN     ASIAN     HISPANIC     OTHER  
PARTNER STATUS \_\_\_\_\_

### PARTNER/FATHER INFORMATION

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_  
ADDRESS (IF DIFFERENT THAN ABOVE) \_\_\_\_\_  
AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
POST-SECONDARY FORMAL EDUCATION (YEARS) \_\_\_\_\_  
OCCUPATION/PLACE OF EMPLOYMENT \_\_\_\_\_

### PREVIOUS PREGNANCY AND DELIVERY HISTORY

NUMBER OF PREVIOUS PREGNANCIES \_\_\_\_\_ NUMBER OF PREVIOUS LIVE BIRTHS \_\_\_\_\_  
OTHER PREVIOUS PREGNANCY/DELIVERY OCCURRENCES \_\_\_\_\_  
MOTHER'S HEIGHT \_\_\_\_\_ MOTHER'S PREPREGNANCY WEIGHT \_\_\_\_\_  
METHOD OF CONCEPTION     COITUS     ARTIFICIAL INSEMINATION     IN VITRO     OTHER

### INSURANCE INFO

- NONE
- MEDICAID/MANAGED CARE PROGRAM    YES \_\_\_ NO \_\_\_  
ID # \_\_\_\_\_  
SEQUENCE# \_\_\_\_\_
- INSURANCE CO NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PLAN NAME \_\_\_\_\_ ID# \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

- I would like to be added to the Midwifery Services e-mail list.
- I would like to be added to the Midwifery Services and Life Cycles Center e-mail lists.
- Please only use my e-mail for personal communication.