# PREGNANCY TEST – UCG

The following information is needed for us to provide you with this service. All information is STRICTLY CONFIDENTIAL. Please answer ALL questions.

**DATE**:_____**NAME**:_____

**Social Security #**:_____ **Phone #**:_____

**Birthdate**: _____**Age**:_____ **Marital Status**:_____

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

Number of Persons living in the home: _____ Income: $_____ per week/month/annually
Public Assistance: _____ Yes _____No Private Insurance: _____ Yes _____ No
Are you enrolled in the Farmworker Program? _____ Yes _____ No

**CONTRACEPTIVE HISTORY**: Have you ever used a method of birth control? _____Yes_____No
If yes, what method? _____ How long used_____ who prescribed_____
Was this a planned pregnancy? _____

If this test is positive, would you like to receive information about the following?

| | | |
|---|---|---|
| Local Resources | Yes | No |
| Adoption | Yes | No |
| Will you need referral to a physician? | Yes | No |
| Will you need information regarding health coverage? | Yes | No |

**PREGNANCY HISTORY**: Have you ever been pregnant? _____Age of first pregnancy_____
Number of live births_____Number of living children_____Number of stillbirths_____
Number of miscarriages_____Number of abortions_____Birth types: C-Section_____Vaginal_____
Date last pregnancy ended_____

| | | |
|---|---|---|
| Do you have diabetes when not pregnant? | Yes | No |
| Did you have diabetes with a previous pregnancy? | Yes | No |
| Do you have high blood pressure when not pregnant? | Yes | No |
| Did you have high blood pressure with a previous pregnancy? | Yes | No |

**Height**_____ Weight_____ **BP**_____

**MENSTRUAL HISTORY**: 1st day of last period_____ Are you regular? _____
Number of days between periods_____ Length of period_____ Type of flow_____ Pain? _____

Current Symptoms: _____

Allergies: _____

Current Medications: _____

**********

## FOR OFFICE USE ONLY

**Test Results: _____ Signature: _____ Date: _____**

**Estimated date of delivery: _____**

**Referrals to: WIC ____ Family Planning ____ Healthy Start ____ SRS ____ (letter sent with client)**
**UA ____ Physician ____**

**Client ID: _____**