



Maternal Health History

Mother's Name: _____

Mother's Birth Date: ____/____/____ Your Due Date: ____/____/____ Approx. date of last physical exam: ____/____/____

Phone #1: (____) _____ Phone #2 :(____) _____

Email: _____

Please check yes or no for the following questions. Use the back of this form if you need room for additional information.

- YES NO 1 Have you been diagnosed with a respiratory disease in the last 24 months? ... 25 In the past 12 months, have you been incarcerated in a correctional facility for longer than 72 hours? ...

Consent To Release Test Results

In compliance with Federal, New York and New Jersey State Laws, I have given the Designated Lab permission to test my blood for the following: Human Immunodeficiency Virus HIV, Human T-Cell Lymphotropic Virus (HTLV), Hepatitis, Cytomegalovirus (CMV), Syphilis (RPR), and Alanine Transaminase (ALT). In the event of any positive results, I authorize the Designated Lab to release my results to my doctor listed below:

Ob/Gyn Name: _____ Dr. Phone #: (____) _____ Dr. Address: _____ Street _____ City _____ State _____ Zip _____

Mother's Consent / Signature: _____ Date ____/____/____