Excellence in Women's Healthcare Obstetrics and Gynecology
OB Intake Form

Today's date: _____

First and last name: _____DOB: _____

Phone number: _____ Cell/Home/Work (circle one)

Occupation: _____

Father of Baby's Full name: _____DOB: _____

Menstrual History-

How often do you have your period? _____

How long is your period? _____

What was the first day of your last period? _____

At what age did you start your period? _____

Were you on birth control at time of conception? _____

When did you take a pregnancy test? _____

Past Pregnancies-

How many times have you been pregnant? _____

How many children do you have? _____

How many miscarriages? _____

How many abortions? _____

Pregnancies in order, including miscarriages and abortions,

1. Date: _____ GA Weeks: _____ Length of Labor: _____
   Birth weight (lbs): _____ Sex: _____
   Baby Name: _____ Type of Delivery: _____
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm labor (Y/N): _____

2. Date: _____ GA Weeks: _____ Length of Labor: _____
   Birth weight (lbs): _____ Sex: _____
   Baby Name: _____ Type of Delivery: _____
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm labor (Y/N): _____

3. Date: _____ GA Weeks: _____ Length of Labor: _____
   Birth weight (lbs): _____ Sex: _____
   Baby Name: _____ Type of Delivery: _____
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm labor (Y/N): _____

4. Date: _____ GA Weeks: _____ Length of Labor: _____
   Birth weight (lbs): _____ Sex: _____
   Baby Name: _____ Type of Delivery: _____
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm labor (Y/N): _____

5. Date: _____ GA Weeks: _____ Length of Labor: _____
   Birth weight (lbs): _____ Sex: _____
   Baby Name: _____ Type of Delivery: _____
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm labor (Y/N): _____

Medications:

_____
_____
_____

Surgeries:

_____
_____
_____

Hospitalizations:

_____
_____
_____

Family history:

_____
_____
_____

Social History-

Have you used drugs other than those for medical reasons in the past 12 months? Yes/No

If yes, type? _____

Marital Status: _____Current living status: _____
_____

Number of adults/children living in household: Adults: _____ Children: _____

Tobacco use: Yes/No

When did you start smoking? _____ When did you stop smoking?_____

How long has it been since you last smoked? _____

Caffeine? Yes/No

Do you smoke Marijuana? Yes/No

Do you drink alcohol? Yes/No

Traveling outside of US? Yes/No

Exercise? Yes/No

OB HISTORY-

Heart Disease: Yes/No

Autoimmune Disorder: Yes/No

Neurologic/Epilepsy: Yes/No

D (Rh) sensitized: Yes/No

Operations/hospitalizations: Yes/No

Diabetes: Yes/No

Kidney disease/UTI: Yes/No

Varicosities/Phlebitis: Yes/No

Pulmonary (TB Asthma) : Yes/No

Anesthetic Complications: Yes/No

Hepatitis/Liver Disease: Yes/No

Thyroid/Dysfunction: Yes/No

History of blood transfusion: Yes/No

Seasonal allergies: Yes/No

Uterine anomaly/DES: Yes/No

Hypertension: Yes/No

Depression/Postpartum depression: Yes/No

Trauma/Violence: Yes/No

GYN Surgery: Yes/No

Infertility: Yes/No

Other:_____

Genetic Screening/Teratology Counseling- <u>(For Mom and Dad of the baby)</u>

Patients age > 35 years of estimated date of delivery: Yes/No

Neural Tube Defect: Mom/Dad/No

Canavan Disease: Mom/Dad/No

Maternal Metabolic Disorder: Mom/Dad/No

Recurrent pregnancy loss of stillbirth: Yes/No

Sickle Cell Disease or trait: Mom/Dad/No

Down Syndrome: Mom/Dad/No

Tay-Sachs: Mom/Dad/No

Cogenital Heart Defect: Mom/Dad/No

Muscular Dystrophy: Mom/Dad/No

Mental Retardation/Autism: Mom/Dad/No

Other Inherited genetic or chromosomal disorder: Mom/Dad/No

Hemophillia or other blood disorders: Mom/Dad/No

Thaiassemia (Italian , Greek, Mediterranean or Asian) MCV <89: Mom/Dad/No

Cystic Fibrosis: Mom/Dad/No (if yes, was person tested for fragile X?) _____

Patient or baby's father had a child with birth defects not listed: Yes/No

Illicit/Recreational drugs/Alcohol since last menstrual period: Yes/No

Infection History:

Live with someone with TB or exposed to TB: Yes/No

Patient or partner with genital herpes: Yes/No

Rash or viral illness since last menstrual period: Yes/No

History of STD, Gonorrhea, Chlamydia. HPV, Syphilis: Yes/No

History of MRSA: Yes/No

Varicella/Chicken pox status: _____