New Obstetric Patient Intake Form

What is the **first** day of your last menstrual period: _____Height:_____Weight:_____
Most Recent **Pap** Smear (month/year): _____/_____
Any history of procedures on the cervix? _____ LEEP/laser _____Cone _____Freezing/Cryo
If yes, approximately what year(s)? _____
Is this pregnancy the result of infertility treatment? If yes, _____IVF _____IUI _____other (explain below)
_____

Current ***Medications/Dosages***: all Prescription Meds ***and*** over-the-counter Supplements, Vitamins, Herbs
_____
_____
_____
_____

Drug Allergies:
_____
_____

Allergy to ***Penicillins***? ___yes ___no
If yes, type of reaction (ex. rash, anaphylaxis)_____
Allergy to Codeine? ___yes ___no If yes, type of reaction_____
Latex Allergy? ___yes ___no
If yes, type of reaction_____
Any environmental or food allergies? (ex. eggs, peanuts) ___yes ___no
If yes, please list allergy and type of reaction:
_____
_____

Pregnancy History:

Total Number of Pregnancies: _____
Number of Vaginal Deliveries: _____ Number of C-Section Deliveries:_____
Number of pregnancy losses prior to 14 weeks: _____

*We will take a *detailed p*regnancy history with you at your next visit. Please have this info for *each* pregnancy readily available for review: year/weeks gestation at birth/type of delivery/anesthesia/location/any significant complications during the pregnancy, birth, and postpartum period.*

Pertinent Family History for Yourself AND Father of Pregnancy:

	Mother of Baby	**Father of Baby**
Congenital Heart defect requiring surgery	____Yes____No	____Yes____No
Spina Bifida/ Neural Tube Defect	____Yes____No	____Yes____No
Cystic Fibrosis	____Yes____No	____Yes____No
Chromosomal Abnormality	____Yes____No	____Yes____No
Trisomy 21, Turner Syndrome	____Yes____No	____Yes____No
Bleeding Disorder, Hemophilia	____Yes____No	____Yes____No
Other Structural Birth Defects	____Yes____No	____Yes____No
Other Genetic Disorders	____Yes____No	____Yes____No

If yes for any, please detail specific relationship of affected person to you and/or the father of the pregnancy:

_____

_____

Social History:

Relationship Status ____Single ____Married ____Partnered ____Widowed ____Divorced ____Separated

Partner Name/Contact Number _____

Pregnancy Support Person/Contact Number_____

Current Household members_____

Do you have indoor cats/litter box? ____Yes____No

Do you feel safe in current home situation? ____Yes____No

Type/Frequency of Exercise_____

Occupation _____

*Please turn in FMLA/employer paperwork to the *front office* for completion during the pregnancy.

Past Surgeries/Procedures that required General Anesthesia-Please List Year/Type

_____

_____

_____

_____

_____

Personal Family History

	Relationship & Age at Diagnosis
Yes____No____Breast Cancer	_____
Yes____No____Uterine Cancer	_____
Yes____No____Ovarian Cancer	_____
Yes____No____Colon Cancer	_____
Yes____No____Diabetes	_____
Yes____No____Autoimmune Disorders	_____
Yes____No____Blood Clotting disorders	_____

_____

_____

Personal Medical History: *Please Mark for Each Line & Circle Choice as needed*

Yes____No____History of Hypertension requiring medication
Yes____No ___ History of Heart Disease
Yes____No____History of Asthma or other Chronic Lung Disease
Yes____No____History of Thyroid Dysfunction----- Hyperthyroid Hypothyroid
Yes____No____History of Diabetes Mellitus---- Type 1 Type 2
Yes____No____History of Pre-diabetes, Hyperinsulinemia, or PCOS
Yes____No____History of Gestational Diabetes during Prior Pregnancy
Yes____No____History of Seizures/Seizure Disorder/Epilepsy. If yes, Date of last seizure_____
Yes____No____History of DVT and/or Pulmonary Embolus If yes, Year of occurrence_____
Yes____No____History of Autoimmune Disease (Ex. Lupus, Rheumatoid Arthritis, Crohn's)
Yes____No____History of Liver disease
Yes____No____History of Kidney disease
Yes____No____History of Kidney Stones
Yes____No____History of Gastrointestinal (stomach) disorders
Yes____No____History of Depression or Anxiety
Yes____No____History of Trauma/Violence-physical or sexual
Yes____No____History of Cancer
Yes____No____History of Complications with Anesthesia
Yes____No____History of Anemia
Yes____No____History of Blood Transfusion. If yes, year_____
Yes____No____Do you consent to a blood transfusion in the event of an emergency ?
Yes____No____History of Covid Infection. If yes, year____
Yes____No____History of Covid Vaccination. If yes, year of most recent_____
Yes____No____History of Long Haul Covid Syndrome
Yes____No____History of Scoliosis. If yes, have you had surgery? _____
Yes____No____Tobacco use since confirmed pregnancy: cigarettes, vape, dip, chew. If yes, amount?_____
Yes____No____Alcohol use since confirmed pregnancy. If yes, amount and frequency? _____
Yes____No____Marijuana use. If yes, frequency and date last used_____
Yes____No____History of recreation drug use since confirmed pregnancy. If yes, type & date last used_____
Yes____No____History of Participation in Drug/Alcohol Rehab Program. If yes, year_____
Yes____No____History of Chicken Pox or had the chicken pox vaccine
Yes____No____History of indoor cats/litter box