OB INTAKE FORM

Patient Name____

Date of Birth______________________________ Date form was completed ___________________________

Your Age:_____

Pregnancy desired: yes no

Pregnancy planned: yes no

Contraception at time of conception: _______________

First day of last period:__________________

How confident are you of this date of last period? Very High High Low

Was this period normal in timing, duration and flow? Yes No

Are periods typically regular and predictable? Yes No

Conception Date (if known):______________

Current symptoms (circle):

Nausea: Occasional Yes No

Vomiting: Occasional Yes No

Breast tenderness: Yes No

Abdominal pain: Yes No

Vaginal bleeding: Yes No

Vaginal discharge: Yes No

Headache: Yes No

Cravings for things that are not edible (dirt, metal, etc): Yes No

Review of systems (circle any that apply-add any symptoms not listed):

Constitutional: Fatigue Sleep difficulty

Eyes: Vision changes

ENT: Nasal congestion Ear pain Sore throat

Cardiovascular: Chest pain Heart palpitations Fainting

Respiratory: Trouble breathing Short of breath Cough

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Bloody stool

Genitourinary: Vaginal discharge Vaginal bleeding Pelvic pain

Musculoskeletal: Joint pain Back pain

Skin and/or breasts: Rash Breast tenderness Itching

Neurological: Headache Double vision Seizures

Psychiatric: Depression Anxiety Hallucinations Bad Relationship/Abuse

Endocrine: Weight Gain Hair loss

Heme/Lymphatic: Swollen lymph nodes (glands)

Allerg/Immuno: Allergies Rash

Past Obstetrical history:

Total Preg	Full Term	Premature	AB induced (abortion)	AB Spont (miscarriage)	Ectopic (tubal)	Multi Births	Living

Past Pregnancies (last five) MOST RECENT FIRST - INCLUDE miscarriages or abortions

Date M/Y	Weeks	Labor duration	Birth Wt	Sex	Delivery Type	Anesthesia	Place of Delivery	Premie ?	Complications?
					Vaginal C section			Y/N	
					Vaginal C section			Y/N	
					Vaginal C section			Y/N	
					Vaginal C section			Y/N	
					Vaginal C section			Y/N	

Past Gynecologic history:

What age at onset of period?	
Regular Period:	Yes No
Average interval between period:(first day to first day)	
Length of period:	
Flow:	
Maternal age >35 on due date:	Yes No

Stillbirths: Yes No

Pregnancy or labor complications: Yes No

Blood transfusion or previous pregnancy with blood type mismatch: Yes No

Fetal abnormalities: Yes No

Past medical history:

Diabetes	Yes No	D (Rh) Sensitized	Yes/No
High Blood Pressure	Yes No	Pulmonary (TB, Asthma)	Yes No
Heart Disease	Yes No	Allergies	Yes No
Autoimmune disorder	Yes No	Breast	Yes No
Kidney Dz (UTI)	Yes No	GYN Surgery	Yes No colposcopy
Neuro/epilepsy (Seizures)	Yes No	Surgery/Hosp (Yr & reason)	Yes No
Psychiatric	Yes No	Anesthetic Complications	Yes No
Hepatitis/Liver/GI	Yes No	History of Abnormal Pap	Yes No
Varicosities/Phlebitis	Yes No	Uterine anomaly / DES	Yes No
Thyroid Dysfunction	Yes No	Infertility	Yes No
Trauma/Dom.violence	Yes No	Relevant FH	Yes No
History of blood transfusion	Yes No	Other	

Habits	Amt/day PrePreg	Amt/day Preg	# Yrs use	Comments
Tobacco	Yes No			
Alcohol	Yes No			
Drugs	Yes No			

Rheumatic fever: Yes No

Blood dyscrasia: Yes No

Major accidents: Yes No

Infection history:

High Risk Hep B/ Immunized?	Yes No Yes No	Rash/Viral illness since last menstrual period	Yes No
Exposure to TB	Yes No	History of STD	Yes No
Patient/partner w/ history of herpes?	Yes No	Exposure to cats/Litter	Yes No
High risk AIDS	Yes No	Consumes wild game/raw meat	Yes No

Current medications:

Name **Dose** **Why do you take this?**

Other medications since Last period:

Allergies:

Social history:

Baby's Father's name:

Father's occupation:

Marital status:

Your occupation:

Environmental work hazards: Yes No

Radiation exposure: Yes No

Chemical/toxin exposure: Yes No

Hot tub/sauna: Yes No

Support system: Good Fair Poor

Family history/Genetics Screening (includes anyone in either family):

Are you and baby's father related by blood?	Yes No	Tay-Sachs	Yes No
Twins:	Yes No	Muscular Dystrophy	Yes No
Down's Syndrome	Yes No	Huntington's Chorea	Yes No
Cystic Fibrosis	Yes No	Mental retardation	Yes No
Thalassemia	Yes No	Other Inherited/chromosome d/o	Yes No
Hemophilia	Yes No	Patient or partner w/ child with birth defects not listed above	Yes No

Other family history:

Diabetes: Yes No

Hypertension: Yes No

Heart disease: Yes No

Pulmonary (lung) disease: Yes No

Renal disease: Yes No

Endocrine disorder: Yes No

Blood dyscrasia: Yes No

Cancer: Yes No

Other: