OBSTETRICAL INTAKE

Date _____

Name _____ Date of Birth _____ Age _____

Referred By/How Did You Hear of Our Office? _____Primary Care Provider_____

□Single □Married □Divorced □Separated

Baby's Fathers Name:_____Date of birth:_____Phone:_____Occupation_____

What kind of relationship do you have with the father of the baby?
□Husband □Friend □Boyfriend □Stranger □Ex-boyfriend or husband

Will he be involved in the pregnancy and caring for the baby? □No □Yes

If no, who will be your support person? Name:_____Phone:_____

Are you: □ Working? If so, what do you do?_____
□ Staying at home □ Going to school
What was the highest grade of school or college you completed?_____

Medications and Dosages (Prescription, or Over the Counter, Vitamins or Herbs)

_____
_____
_____

Pharmacy Used: _____

Allergies (Medication, x-ray dyes, latex, anesthesia or other substances)

Name and Reaction:_____
_____

Menstrual History

Date of last period _____ □Not sure Was your last period: □Normal □Light □Heavy
Duration of bleeding _____ Number of days apart _____
Age at onset of periods _____

Past Pregnancy History

Number of pregnancies:_____ Miscarriages: _____Abortions_____Living Children:_____

Preg #	Date of delivery	Gestational age	Hours in labor	Birth weight	Sex	Place of delivery	Anesthesia	Delivery type

Medical History

Please circle if you have had a history of or are having problems with any of the following:

1. Diabetes
2. High blood pressure
3. Heart disease
4. Immune problems
5. Kidney problems
6. Neurologic/seizure disorder
7. Psychiatric
8. Depression/Postpartum depression
9. Hepatitis/Liver Disease
10. Varicosities/Phlebitis
11. Thyroid Dysfunction
12. Trauma/Violence
13. Blood Transfusion
14. D (Rh) Sensitized
15. Pulmonary/TB/Asthma
16. Seasonal Allergies
17. Drug/Latex Allergies/Reactions
18. Breast Disease
19. Gyn Surgery
20. MRSA Exposure
21. Anesthetic complications
22. Abnormal Pap
23. Abnormal Uterus
24. Infertility
25. DES exposure

Operations/Hospitalizations

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Genetic History

Have you, the father of the baby or any family members had any of the following problems?

Problem	Yes	Which family members?
Thalassemia		
Neural Tube Defect (Spina Bifida)		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs		
Sickle Cell Disease		
Hemophilia/Blood Disorders		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Disease		
Mental Retardation/Autism		
Other genetic or chromosomal		
Have you or the baby's father had a child with a birth defect not listed above?		

Family History

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Yes	Which family members?
Diabetes		
High Blood Pressure		
Heart Disease		
Bleeding Problems		
Cancer/Type		
Other		

Dietary Habits

How many meals/snacks do you eat every day? _____meals and _____snacks per day.

Do you regularly skip meals? □ No □ Yes
How often?_____

How many drinks containing caffeine (soda, coffee, tea) do you drink? □ None □ Yes, _____drinks/day.

Do you eat any of these foods? □ Raw or uncooked meat, fish, or eggs □ Feta or blue cheese □ Lunch Meats

What do you drink on most days? □ Milk □ Juice □ Soda □ Tea □ Coffee □ Water

Social History

Total number of family members (children and others living with you)? _____

Pets at home? _____

Do you have concerns about your housing situation? □ No □ Yes

Have you ever been in a relationship in which you've been kicked,
hit or slapped? □ No □ Yes

Are you concerned for your safety? □ No □ Yes

Has anyone ever forced you to have sex? □ No □ Yes

Have you ever tried to commit suicide? □ No □ Yes
Have you ever seen a counselor or hospitalized for your mental health? □ No □ Yes

Do you have any religious or cultural practices that we need to know
To help us care for you better? □ No □ Yes

Medical History

Have you or your partner ever had a sexually transmitted disease (Gonorrhea, Chlamydia, Genital Herpes, HPV)? □ No □ Yes

Have you received the HPV vaccine? □ No □ Yes

Have you been exposed or infected with Hepatitis B or C? □ No □ Yes

Have you received the Hepatitis B vaccine? □ No □ Yes

Have you ever had chicken pox or a vaccine against chicken pox? □ Yes, which one_____

Have you lived with someone with TB or been exposed to TB? □ No □ Yes

Have you been exposed to x-rays since you became pregnant? □ No □ Yes

Have you been exposed to any chemicals since you became pregnant? □ No □ Yes

Do you exercise? □ No □ Yes

If yes, what type of exercise do you do?

How many times per week? _____ times per week.

Dental Health History

Name of dentist:_____

When was your last dental visit? _____

What was this appointment for? □ Exam □ X-rays □ Cleaning □ Filling

Do your teeth or gums cause you any discomfort at this time? □ No □ Yes

Do you have obvious cavities (black or brown holes in your teeth)? □ No □ Yes

Are your gums red, puffy, and/or bleed easily when you brush? □ No □ Yes

If you have children, do they have cavities and/or fillings? □ No □ Yes

Have you had fillings placed in your mouth in the last 12-24 months? □ No □ Yes

Do you qualify for Medicaid or Medicare insurance? □ No □ Yes

Tobacco use:

Do you smoke?	Current	Former	Never
If yes, how many per day?	Currently:	Pre-pregnancy:	
How long have you smoked?			
If former, year you quit:			
Does anyone in your home smoke?	Yes	No	

Drug Use: please circle yes or no

Have you used drugs other than those required for medical reasons?	Yes No
Have you abused prescription drugs?	Yes No
Do you abuse more than one drug at a time	Yes No
Can you get through the week without using drugs?	Yes No
Are you always able to stop using drugs when you want to?	Yes No
Have you had “blackouts” or “flashbacks? As a result of drug use	Yes No
Do you ever feel bad or guilty about your drug use?	Yes No
Does your spouse/parents ever complain about your involvement with drugs?	Yes No
Has drug abuse created problems between you and your spouse/parents?	Yes No
Have you lost friends because of your use of drugs?	Yes No
Have you neglected your family because of your uses of drugs?	Yes No
Have you been in trouble at work because of your use of drugs?	Yes No
Have you lost a job because of drug abuse?	Yes No
Have you gotten into fights when under the influence of drugs?	Yes No
Have you engaged in illegal activities in order to obtain drugs?	Yes No
Have you been arrested for possession of illegal drugs?	Yes No
Have you ever experienced withdrawal symptoms when you stopped taking drugs?	Yes No
Have you had medical problems as a result of your drug use? (memory loss, hepatitis, bleeding, etc)	Yes No
Have you gone to anyone for help for a drug problem?	Yes No
Have you been involved in a treatment program especially related to drug use?	Yes No

Alcohol Screening

Have you ever…..

Felt the need to cut down on drinking?	Yes	No
Ever felt annoyed by criticism of drinking?	Yes	No
Had guilty feelings about drinking?	Yes	No
Ever had to take a morning “eye-opener”?	Yes	No

Screening Questions for Drugs/Alcohol

Have you used any of the following drugs?

Marijuana	Yes	No
Suboxone/methadone	Yes	No
Cocaine	Yes	No
Heroin	Yes	No
Other		