Name:

Date of Birth:

New OB Intake Form

Last menstrual cycle: _____ Is this unknown, approximate, or definite?
Pre-pregnancy weight: _____ Height: _____
Allergies (medications, supplements, latex, foods): _____
Personal Medical/Surgical History: _____
_____
Please list all medication, supplements, vitamins, and oils you are taking, how often you are taking them, and how much you are taking: _____
_____

Pregnancy History

How many times have you been pregnancy including any miscarriages, abortions, tubal pregnancies, and stillbirths: _____

Date	Weeks Pregnant	Length of Labor	Sex	Birth Weight	Epidural Yes/No	Vaginal/ c-section/ Vacuum/ Forcep	Living Y/N	Who/ Where Delivered	Baby's name	Complications

Did you have any of the following during any pregnancy (circle): Early labor Early birth
Diabetes High blood pressure Preeclampsia Bleeding Problems Kidney Troubles
Seizure/convulsions Anemia/Low iron Hemorrhage Shoulder dystocia Blood Transfusion
Have any of your babies been infected with GBS (group beta strep) after delivery? Yes/No
Any concerns or worries: Yes/No Explain: _____
_____

Any pain? Yes/No Bleeding? Yes/No
Do you get pap smears: Yes/No Have you had an abnormal pap: _____
Will you accept a blood transfusion? Yes/No
Do you smoke cigarettes? Yes/No If yes, how many and for how long? _____
Do you smoke or ingest marijuana/THC? Yes/No If yes, how often? _____
Do you drink alcohol? Yes/ No How many drinks per week before pregnancy_____

Infection Exposure/Vaccination History

Have you ever had tuberculosis or been exposed to someone with tuberculosis? Yes/No
Have you or your partner ever been diagnosed with oral cold sores or genital herpes: Yes/No
Have you had a rash or viral illness since your last menstrual period? Yes/No
Have you ever had MRSA? Yes/No

Do you or your partner have a history of HIV? Yes/No
Do you or your partner have a history of Hepatitis B or C? Yes/No
Have you ever been diagnosed with any of the following (circle all that apply):
Gonorrhea Chlamydia Syphilis Genital Warts Pelvic inflammatory disease
Have you had the chickenpox or the Varicella vaccine as a child? Yes/No/Unsure _____
Have you had the flu vaccine this season? (October - March): Yes/No/
Have you had any other vaccinations this pregnancy: _____

Genetic History

Please circle if you, the father of baby, or anyone in either side of the family has had one of these conditions:

Patient's age 35 years or older at time of delivery
Congenital Heart Defect
Mental Retardation / Autism
Sickle cell disease or trait (African)
Muscular dystrophy
Maternal metabolic disorder (i.e Type 1 Diabetes, PKU)
Recurrent pregnancy loss, or a stillbirth
Down syndrome If yes, was the person tested for Fragile X? Yes/No
Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)
Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV < 60
Neural tube defect (Meningomyelocele, Spina bifida, or Anencephaly)
Familial dysautonomia
Huntington's chorea
Canavan disease
Hemophilia or other blood disorders
Cystic fibrosis
Medications (including supplements, vitamins, herbs or OTC drugs) illicit/recreational drugs/alcohol since last menstrual period: _____
Other inherited genetic or chromosomal disorder not listed: _____
Patient or baby's father had a child with birth defects not listed above: _____
Are you interested in genetic screening? Yes/No/Want to know more

Family History

Please indicate if your mother (M), father (F), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF) has any of the following:

Breast Cancer _____
Colon Cancer _____
Lung Cancer _____
Other Cancers _____
Mental Illness _____
Alcoholism _____
Drug abuse _____
Heart Disease _____
Diabetes _____
Seizures/epilepsy _____
Thyroid disease _____
Blood clots/Bleeding disorders _____
Stroke _____
High Cholesterol _____
Kidney Disease _____
High Blood Pressure _____
Asthma _____

Please list any questions or concerns you have for us today.

_____
_____
_____