Tuality Healthcare

Patient identification

OB intake patient information

Name: _____ **DOB:** ____/____/____ **Today's date:** ____/____/____
Last First M mo day yr mo day yr

Tel: _____ **Work:** _____ **Cell:** _____

Primary care provider: _____

Referred by: _____

Reason for today's visit?_____

Pregnancy dating:

First day of last menstrual period: _____ ❒ Certain ❒ Approximate (select one)

Tracking ovulation: ❒ Yes ❒ No If yes, date of ovulation: _____ Method of tracking: _____

Did you use fertility treatment to achieve this pregnancy? ❒ Yes ❒ No **Which** method? _____

Were you on birth control when you became pregnant? ❒ Yes ❒ No **Which** method? _____

Past medical and family history: For yourself, provide details and dates. For family members, please check (✓) if yes. In the **"other"** column please specify who the family member is, such as: Maternal Grandmother (MGM), Maternal Grandfather (MGF), Paternal Grandmother (PGM), or Paternal Grandfather (PGF).

❒ Check here if you were adopted

	Self	Mother	Father	Sister	Brother	Child	Other
Alcoholism							
Arthritis							
Asthma							
Anxiety							
Bleeding disorder, please specify:							
Bowel problems, please specify:							
Cancer, please specify:							
Chickenpox							
Depression							
Diabetes							
Drug abuse							
Eating disorder, please specify:							
Emphysema							
Heart disease							
Heartburn							
Hepatitis, please specify							
High blood pressure							
High cholesterol							
Osteoporosis							
Seasonal allergies							
Stroke							
Thyroid disease							
Ulcer							
Other							
Other							

Surgical history:

List any surgeries you have had: (i.e wisdom teeth removal)

Date

_____

_____

_____

_____

Social history

Tobacco use:

Any form of tobacco use past or present (cigarettes or smokeless tobacco): ❒ Yes ❒ No

Current use: ❒ Yes ❒ No If yes, how many packs per day: _____ Number of years: _____

Are you interested in quitting or desire tobacco cessation information? ❒ Yes ❒ No

Past use: ❒ Yes ❒ No If yes, number of years: _____ Quit date: _____

Other tobacco use: ❒ Pipe ❒ Cigar ❒ Snuff ❒ Chew ❒ Never

Alcohol use:

Do you drink alcohol? ❒ Yes ❒ No If yes, # of drinks per week: _____

Quit for pregnancy? ❒ Yes ❒ No

Drug use:

Do you use marijuana or other recreational drugs? ❒ Yes ❒ No

Have you ever used needles to inject drugs? ❒ Yes ❒ No

Sexual activity:

Currently sexually active: ❒ Yes ❒ No If yes, partner's name: _____

Sexual partner(s) is/are/have been: ❒ Male ❒ Female ❒ Both

Activities of daily living:

1. Have you ever served in the military? ❒ Yes ❒ No
2. Have you ever had a blood transfusion? ❒ Yes ❒ No
3. Do you have any concerns about caffeine? ❒ Yes ❒ No
4. Do you have any occupational exposures (chemicals, x-rays, chemo, etc)? ❒ Yes ❒ No
5. Do you participate in any extreme or hazardous hobbies? ❒ Yes ❒ No
6. Do you have any sleep concerns? ❒ Yes ❒ No
7. Are you currently experiencing any unusual stressors? ❒ Yes ❒ No
8. Do you have any weight concerns? ❒ Yes ❒ No
9. Do you eat a special diet such as vegetarian or gluten-free? ❒ Yes ❒ No
10. Do you have any previous back injuries or scoliosis? ❒ Yes ❒ No
11. Do you exercise? If yes, what type: _____ ❒ Yes ❒ No
12. Do you wear a helmet when riding a bicycle? ❒ Yes ❒ No
13. Do you wear a seatbelt in the car? ❒ Yes ❒ No
14. Do you do self-breast exams? ❒ Yes ❒ No

Social / Safety documentation:

1. Who do you live with? _____
2. Do you have any cats in your home? ❒ Yes ❒ No
3. Do you have working smoke alarms? ❒ Yes ❒ No
4. Are there any guns in the home? ❒ Yes ❒ No
5. Do you have a religious preference? _____
6. Would you agree to a blood transfusion if needed? ❒ Yes ❒ No
7. What is your racial ethnicity: _____
8. Primary language: _____
9. How many years of education do you have? _____ Type of degree (if applicable): _____
10. What is your occupation? _____
11. What is your partner's occupation? _____
12. Has there been a history of violence, trauma, or physical, sexual, or emotional abuse in your family, or in your relationship (past or present)? ❒ Yes ❒ No If yes, _____

_____

_____

_____

Obstetric history **❒ Check here if you have never been pregnant**

Please list all pregnancies in order (from oldest to most recent). For pregnancy outcome, please list type of delivery: **Term** (37 + weeks), **Pre-term** (<37 weeks), **miscarriage, abortion,** or **ectopic pregnancy.** If you need more room, please use the back of the form. **For history of C-section, please provide reason.**

Pregnancy Outcome	Date of Delivery	# of weeks	Labor Length	Baby's Weight	Sex (M / F)	Delivery Type (Vag or C/S)	Epidural / IV med / none	Living (Y / N) / Name	Delivery location / complications during pregnancy or delivery/ reason for C-section
1.									
2.									
3.									
4.									
5.									
6.									

Gynecologic history:

1. Age of first period: _____
2. First day of last menstrual period: _____
3. Are your periods regular: ❒ Yes ❒ No
4. How often do you have your period: every _____ days
5. How long does your period last: _____ days
6. Date of last pap smear: _____ Result: _____
7. Have you ever had an abnormal pap smear: ❒ Yes ❒ No If yes, please list year and treatment for each abnormal pap: _____
8. History of sexually transmitted infections? ❒ Yes ❒ No If yes, type(s):_____

Social data / habits / exposure:

1. Spouse / partner's name: _____
2. Was this a planned pregnancy: ❒ Yes ❒ No
3. Are you considering placing baby up for adoption? ❒ Yes ❒ No
4. Tobacco Cessation information needed? ❒ Yes ❒ No
5. HIV testing is performed as a standard of care and will be drawn with your prenatal labs in each pregnancy. If you have concerns, please discuss this with your provider.
6. Will you be 35 or over at time of delivery: ❒ Yes ❒ No

Genetic history: for any positive answers, **please list the affected family member.**

	Your family	Partner's family	Negative
Sickle cell disease or trait (African)			
Thalassemia (Italian, Greek, Medit or Asian)			
Tay-Sachs disease (Jewish, Cajun, French Canadian)			
Down syndrome			
Developmental delay, mental retardation, or autism			
If yes, was the person tested for Fragile X?			
Neural Tube Defects (Spina Bifida, Meningocele, or Anencephaly)			
Cystic Fibrosis			
Huntington's Chorea			
Muscular Dystrophy			
Hemophilia			
Definite / Probable ADD / ADHD			
Other chromosomal abnormality or genetic disorders?			
Previous pregnancy and/or child with birth defect(s)?			

Medication list / preferred pharmacy:

Please list all medications, vitamins, and supplements you are currently taking or have been prescribed. Please list additional medications on the back of this form.

Name of Medication / vitamin / supplement	Dosage	How often do you take it?
1.		
2.		
3.		
4.		
5.		
6.		

What is your preferred pharmacy: _____

Location: _____

Allergies: ❒ **No known drug allergies**

List medications / food / latex allergy **Reaction**

_____

_____

_____

_____

_____

_____

Other information you wish to share with your provider:

_____

_____

_____

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_____

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