OB PATIENT SCREENING

APPT: _____
U/S: _____
F/U APPT: _____
OB ED: _____
LAB: _____

Name: _____ ID: _____ Phone: _____

DOB: _____ Age: _____ Referred From: _____

Insurance: _____ ID #: _____ Auth. Needed? **YES** **NO**

LMP: _____ EDD: _____ W: _____ D: _____ INFORMED OF DRUG POLICY: ____

- Have you had any prenatal care to date? YES NO
  - Where was care provided? _____
  - Tests performed: _____
  - Have you travelled to a Zika Virus infected area within the last 12 weeks? **YES** **NO**
- Date of Last Visit: _____
  - Regularly? **YES** **NO**
- First Pregnancy **YES** **NO**
- How many previous pregnancies? _____

Outcomes: Date Sex Deliv Type

Problems during pregnancy: _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Gestational Diabetes:	**YES**	**NO**	_____
Hypertension	**YES**	**NO**	_____
HX preterm labor	**YES**	**NO**	_____
Pre eclampsia (toxemia)	**YES**	**NO**	_____
Premature rupture of membranes	**YES**	**NO**	_____
HELLP Syndrome	**YES**	**NO**	_____
Unplanned hospitalizations/procedures?	**YES**	**NO**	_____

Current Weight: _____ Height: _____ BMI: _____ Greater than 275lbs? **YES** **NO**

Current health problems _____

_____

_____

Current Medications _____

_____

_____

Past/Current Substance Abuse **YES** **NO** _____

_____

Do you have any objections to accepting blood products in an emergency situation? **YES** **NO**

Additional Comments _____

_____

PATIENT ACCEPTED: _____ PATIENT NOT ACCEPTED: _____ PHYSICIAN: _____ DATE: _____