NAME: _____ DOB: _____ID: _____ MD: _____

COMPLETE FORM ENTIRELY –DO NOT LEAVE ANY BLANKS

OB INITIAL INTAKE INFORMATION

Father of Baby Information:

(list- medical problems such as Diabetes, Hypertension, Heart, Cancer or any major medical problems)

Father of baby health history _____

Father of baby family history _____

Patient Surgical History: (List in detail)

Gynecological procedures/surgeries _____

Other procedures/surgeries _____

Hospitalizations _____

Anesthesia Complications _____

Patient Family History:

Circle all that apply (Designate family member –mother, father, brother, sister, grandparent-maternal/paternal)

(ex. M, F, B, S, MGM, MGF, PGM, PGF)

Hypertension	_____	Diabetes	_____	Heart Disease	_____
Kidney Disease	_____	Breast Cancer	_____	Uterine Cancer	_____
Respiratory Disease	_____	Colon Cancer	_____	Other Cancers	_____
Ovarian Cancer	_____	Depression	_____	Thyroid Disease	_____
Weight Disorders	_____	Endometriosis	_____	Migraines	_____
Seizures	_____	Lung Cancer	_____	Blood Clots	_____
Osteoporosis	_____	Stroke	_____	Psychiatric Care	_____

Other Medical History _____

Patient Social History:

Tobacco Use: Yes No

Current every day smoker
Current some day smoker
Former smoker
Never Smoker
Passive smoke exposure

Drug use: Yes No

Marijuana
PCP
Cocaine
Heroin
Other:

Caffeine Use: Yes No
Alcohol Use: Yes No
Regular Exercise: Yes No

Number of Children at home: _____
Patient Education: (Last Grade completed: _____
Occupation: _____

Pre-pregnancy weight: _____

***Patient Allergies:** _____
(Drug, food or environmental)

Patient Past Medical History:

please circle if it applies to you

Diabetes	Comments _____
Hypertension	Comments _____
Heart Disease	Comments _____
Autoimmune Disorder	Comments _____
Kidney Disease/UTI	Comments _____
Neurologic/Epilepsy	Comments _____
Psychiatric	Comments _____
Hepatitis/Liver Disease	Comments _____
Varicosities/Phlebitis	Comments _____
Thyroid Disease	Comments _____
Trauma/Violence/Domestic Abuse	Comments _____
Blood Transfusions	Comments _____
D (Rh) Sensitized	Comments _____
Pulmonary (Lung) Disease	Comments _____
Breast Disease	Comments _____
GYN Problems	Comments _____
Abnormal Pap	Comments _____
Uterine Anomaly (Abnormality)	Comments _____
DES Exposure	Comments _____
Infertility	Comments _____

Patient Menstrual History:

Last Menstrual period (LMP): _____

Menarche (age you started having periods):_____

Menses Interval (how many days between periods):_____

Were you on any birth control at the time of conception:_____

Past Pregnancy History:

Gravida (How many times have you been pregnant, including this pregnancy?_____

Term births (37-40 wks) _____

Premature births (less than 37 wks) _____

Living Children _____

Multiple births (Twins) _____

Vaginal deliveries_____

C/Section _____

Miscarriages _____

Elective Abortions _____

Stillbirths _____

Ectopic _____

Previous VBAC (Vaginal Birth After C/Section) attempt _____

Medications, drugs or alcohol since LMP ?

If yes, List all medications-prescriptions, OTC, drugs and alcohol:

_____

NAME: _____ DOB: _____ID: _____ MD: _____

COMPLETE FORM ENTIRELY –DO NOT LEAVE ANY BLANKS

OB INITIAL INTAKE INFORMATION

List previous pregnancies, miscarriages, elective abortions, ectopic: (in date order)
MUST COMPLETE

Delivery Date	Weeks Gest.	Preterm Labor	Delivery Type	Hours Labor	Anesth. Type	Delivery Location	Infant Sex	Birth Wt.	Name	Comments

Genetic History: (circle yes or no)	**Patient**		**Father of Baby**		
Thalassemia	Yes	No	Yes	No	Comments: _____
Neural Tube Defect	Yes	No	Yes	No	Comments: _____
Congenital Heart Defect	Yes	No	Yes	No	Comments: _____
Down's Syndrome	Yes	No	Yes	No	Comments: _____
Tay-Sachs	Yes	No	Yes	No	Comments: _____
Sickle Cell Disease/Trait	Yes	No	Yes	No	Comments: _____
Hemophilia	Yes	No	Yes	No	Comments: _____
Muscular Dystrophy	Yes	No	Yes	No	Comments: _____
Cystic Fibrosis	Yes	No	Yes	No	Comments: _____
Huntington's Disease	Yes	No	Yes	No	Comments: _____
Mental Retardation	Yes	No	Yes	No	Comments: _____
Fragile X	Yes	No	Yes	No	Comments: _____
Other Genetic or Chromosomal Disease	Yes	No	Yes	No	Comments: _____
Child born with other Birth defect	Yes	No	Yes	No	Comments: _____
More than 3 miscarriages	Yes	No			
History of Stillbirth	Yes	No			
Patient's Age over 35 years	Yes	No			

Infection Risk History:	**(circle yes or no)**		
HIV/Hep B high risk behavior	Yes	No	
Hep B Immunized (3 dose vaccine series)	Yes	No	
TB Exposure	Yes	No	
Patient with history of Genital Herpes	Yes	No	
Sexual partner with history of Genital Herpes	Yes	No	
History of STD (GC, Chlamydia, Syphilis, HPV)	Yes	No	Specific type: _____
Rash, Viral, or (Fever) Illness since Last Menstrual Period	Yes	No	
Exposure to Cat Litter	Yes	No	
Chicken Pox Immune Status	Hx of Disease	Immune	Vaccine
History of Parvovirus (Fifth Disease)	Yes	No	
Occupational Exposure to Children Teacher	Daycare	Other	

Environmental Exposure:

X-Ray Exposure since LMP	Yes	No
Chemical or other exposure	Yes	No

Hospital of delivery: Citizens or DeTar (Circle one)

_____ Date: _____

(Patient Signature)

Patient email address:_____