Holmes Family Care

2564 NW Edenbower BLVD Ste126
Roseburg OR 97471
Phone: (541)672-7718 Fax: (541)315-7125
Email: office@holmesfamilycare.com

OB Intake Form:

Date: _____

Full Name: _____ DOB: _____

Phone number: _____ Cell/Home/Work (circle one)

Mother's Occupation: _____

Father of baby's full name: _____ DOB: _____

Father's occupation: _____ Phone number: _____

Material Status: O Single O Married O Divorced O Widowed O Separated O Life Partner
Parents of Baby: O Married O live together O Divorced O Single Parent O Remarried

Number of adults/children in household: Adults: _____ Children: _____

Laboratory preference: O Mercy O Quest O Lab Corp O InterPath

Do you plan on Vaccinating your child? O Yes O No

OB History:

Heart Disease: O Yes O No

Autoimmune Disorder: O Yes O No

Neurologic/Epilepsy: O Yes O No

Hepatitis/Liver Disease: O Yes O No

Thyroid dysfunction: O Yes O No

History of Blood Transfusion: O Yes O No

D (RH) sensitized? O Yes O No

Seasonal Allergies: O Yes O No

Operations/Hospitalizations: O Yes O No

Uterine anomaly/DES: O Yes O No

Diabetes: O Yes O No

Hypertension: O Yes O No

Kidney Disease: O Yes O No

Depression/postpartum depression: O Yes O No

Varicosities/phlebitis: O Yes O No

Trauma/Violence: O Yes O No

Illicit/Recreational Drugs: O Yes O No

Pulmonary (TB, Asthma): O Yes O No

GYN Surgery: O Yes O No

Anesthetic Complications: O Yes O No

Infertility: O Yes O No

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Genetic Screening/Teratology Counseling: (For Mother and Father of the baby)

Patients age >35 years at estimated date of delivery: O Yes O No

Thalassemia (Italian, Greek, Mediterranean or Asian) MCV <80: O Mother O Father O Neither

Neural Tube Defect: O Mother O Father O Neither

Congenital Heart Defect: O Mother O Father O Neither

Down Syndrome: O Mother O Father O Neither

Tay-Sachs: O Mother O Father O Neither

Canavan Disease: O Mother O Father O Neither

Sickle Cell Disease or Trait: O Mother O Father O Neither

Muscular Dystrophy: O Mother O Father O Neither

Cystic Fibrosis: O Mother O Father O Neither

Hemophilia or other blood disorders: O Mother O Father O Neither

Mental retardation/Autism: O Mother O Father O Neither

If yes, was person tested for Fragile X? O Yes O No

Other Inherited genetic or chromosomal disorder: O Mother O Father O Neither

If yes, Name of disorder: _____

Maternal Metabolic Disorder: O Mother O Father O Neither

Birth Defects not listed: _____ O Mother O Father

Recurrent Pregnancy loss or still birth: O Yes O No

Medications/Illicit/Recreational drug/alcohol use since last menstrual period: O Yes O No

Infection History:
Live with someone with TB or exposed to TB: O Yes O No
Patient or partner with genital herpes: O Yes O No
Rash or Viral Illness since last menstrual period: O Yes O No
History of STD (Gonorrhea, Chlamydia ,HPV, Syphilis): O Yes O NO
If yes, which one? _____
History of MRSA: O Yes O No

Vaccinated or had Chickenpox (Mother and Father): _____

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Obstetric/Gynecological History:

Frequency of Cycles: ____ Days Age of first Menstrual Cycle: _____
When was the first day of your last menstrual cycle: _____
Were you on Birth Control at time of conception: O Yes O NO What form if yes: _____
Date that you took a pregnancy test: _____
Date of your last PAP: _____
Have you had any abnormal PAP results: O Yes O No If yes, Results: _____

Pregnancies: Total ___ Full term ___ Premature ___ Miscarriages ___ Abortions ___

Pregnancies in order, including miscarriages and abortions:

1. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____
2. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____
3. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____
4. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____

5. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____

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Medical History

Medications: O No change

Medications:	Dose:	Times Per Day

Allergies O No change

Allergy:	Reaction:

Surgeries O No change

Type (Specify Left/Right)	Date:	Location/Facility:

Hospitalizations: O No change

Reason:	Date:	Location/Facility:

Social History:

Tobacco Use:
Do you or have you ever smoke Cigarettes: O Yes O No (if yes please answer questions below)
Current: Pack/day: ___ Number of years: ___ Are you thinking about quitting: O Yes O No
Past: Quit Date: _____ Packs/day: _____ Number of years smoked: _____
Do you vape: O Yes O No

Do you use Marijuana or other recreational drugs: O Yes O No
Have you used drugs other than those for medical reasons in past 12 months: O Yes O No
Do you drink caffeine: O Yes O No How many cups per day: ____
Do you drink Alcohol: O Yes O No
Have you traveled outside the US in last 30 days: O Yes O No

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Family History:

Name: _____ DOB: _____

Family Members	Statues: (Alive or Deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer	Mental Illness
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Brother(s)								
Sister(s)								
Son(s)								
Daughter(s)								