Holmes Family Care

2564 NW Edenbower BLVD Ste 126
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: _____

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 living in household: Adults: _____ Children: _____

Which lab do you prefer? O Mercy O Quest

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/hospitalization: O Yes O No

Uterine anomaly/DES: O Yes O No

Diabetes: O Yes O No

Hypertension: O Yes O No

Kidney diseases/ UTI: 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

Other: _____

Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

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

Patients age >35 years of estimated date of deliver: 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

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 No O Yes

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

Maternal metabolic disorder: O Mother O Father O Neither

Birt defects not listed: O Yes O No

Recurrent pregnancy loss or still birth: O Yes O No

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

Muscular dystrophy: O Mother O Father O Neither

Cystic Fibrosis: O Mother O Father O Neither

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: O No O Yes:
Gonorrhea: O Yes O No
Chlamydia: O Yes O No
HPV: O Yes O No
Syphilis: O Yes O No

History of MRSA: O Yes O No

Varicella/Chicken pox status: _____

Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

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 No O Yes. What form/method: _____

When did you take a pregnancy test? _____

When was your last PAP? _____

Have you had any abnormal PAP results? O No O 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 deliver: _____ Preterm labor: O Yes O No

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 deliver: _____ Preterm labor: O Yes O No

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 deliver: _____ Preterm labor: O Yes O No

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 deliver: _____ Preterm labor: O Yes O No

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 deliver: _____ Preterm labor: O Yes O No

Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

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:

Have you used drugs other than those for medical reasons in the past 12 months?

O No O Yes. Type: _____

Tobacco Use:

Do you smoke Cigarettes? O No O Yes (please answer the questions below):

Current: Pack/Day: _____ Number of years: _____ Are you thinking about quitting? O No O Yes

Past: Quit Date: _____ Packs/day: _____ Number of years: _____

How long has it been since you last smoked? _____

Do you use Marijuana or recreational drugs? O Yes O No

Do you drink caffeine? O No O Yes. How many cups per day: _____

Do you exercise? O No O Yes. How many times per week? _____

Do you drink alcohol? O No O Yes

Have you traveled outside of the US? O No O Yes

Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

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)								

Other: _____