NAME: _____ DOB: _____ID: _____ MD: _____

OB INITIAL INTAKE INFORMATION

Patient Information
Positive pregnancy test by:_____
Occupation: _____
Type of work: _____
Education (last grade completed): _____
Number of children at home: _____
Hospital of delivery- Detar or Citizens: _____
Newborn's physician: _____

Father of Baby Information
Husband/Father of baby: _____
Occupation: _____
Phone: _____
Father of baby health history: _____
Father of baby family history: _____
Comments: _____
_____

Menstrual History
Last Menstrual Period (LMP) (date):_____
LMP – Character: (circle one) Normal Light Heavy
Menarche (age you starting having periods): _____
Menses interval (how many days between periods): _____
Menstrual flow (how may days do your periods last): _____
Were you on any birth control at time of conception: _____
Date of positive (+) home pregnancy test: _____

Pre-pregnancy weight: _____

Have you had any symptoms since your last menstrual period: (circle all that apply)
Nausea Vomiting Fatigue Irritability Bloating Tender Breasts
Urinary Frequency Other symptoms: (list)

Past Pregnancy History
Gravida (How many times have you been pregnant?):_____
Term births (37-40 wks):_____
Premature births (less than 37 wks):_____
Living Children:_____
Multiple births:_____
Vaginal deliveries:_____
C/Sections:_____
Miscarriages:_____
Elective Abortion:_____
Stillbirths:_____
Previous VBAC (Vaginal Birth After C/Section) attempt:_____
Ectopics:_____

List previous pregnancies, miscarriages, elective abortions, ectopics: (in date order) <u>MUST COMPLETE</u>

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

NAME: _____ DOB: _____ID: _____ MD: _____

Patient Past Medical History

Allergies: (Drug, Food or Environmental) _____

	(circle yes or no)		
Diabetes:	Yes	No	Comments:_____
Hypertension (High Blood Pressure):	Yes	No	Comments:_____
Heart Disease:	Yes	No	Comments:_____
Autoimmune Disorder:	Yes	No	Comments:_____
Kidney Disease/UTI:	Yes	No	Comments:_____
Neurologic/Epilepsy:	Yes	No	Comments:_____
Psychiatric:	Yes	No	Comments:_____
Hepatitis/Liver Disease:	Yes	No	Comments:_____
Varicosities/Phlebitis:	Yes	No	Comments:_____
Thyroid Disease:	Yes	No	Comments:_____
Trauma/Violence:	Yes	No	Comments:_____
Blood Transfusions:	Yes	No	Comments:_____
D (Rh) Sensitized	Yes	No	Comments:_____
Pulmonary (Lung) Disease:	Yes	No	Comments:_____
Breast Disease:	Yes	No	Comments:_____
GYN Problems:	Yes	No	Comments:_____
Abnormal Pap:	Yes	No	Comments:_____
Uterine Anomaly (Abnormality):	Yes	No	Comments:_____
DES Exposure:	Yes	No	Comments:_____
Infertility:	Yes	No	Comments:_____

Surgical History (List in detail)
Uterine Surgery (not C/S):_____
Operations:_____
Hospitalizations:_____
Anesthesia Complications:_____

Social History	(circle yes or no)		(circle one)
Tobacco Use:	Yes	No	Current every day smoker
Year started: _____			Current some day smoker
Year quit: _____			Former smoker
Cigarette packs/day: _____	pack-years: _____		Never smoker
Passive smoke exposure:	Yes	No	
Alcohol Use:	Yes	No	
Caffeine Use:	Yes	No	
Drug Use (current/previous):	Yes	No	

Drug Type: Marijuana PCP Illicit Rx Cocaine Heroin Other: _____

Regular exercise:		Yes	No		
Exercise type:	bicycling	running	swimming	walking	aerobics

Have you been seen by another physician, seen at another facility, or received emergency treatment at a hospital or outpatient clinic since you have become pregnant? _____
If yes, where were you seen? _____Date _____
Treatment or medications received _____
Was lab work or an Ultrasound done? _____If yes (list) _____

NAME: _____ DOB: _____ID: _____ MD: _____

Patient Family History

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

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:_____

Infection Risk History

		(circle yes or no)		
HIV/Hep B high risk behavior:		Yes	No	
Hep B Immunized:		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, Syphillis, 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

Xray Exposure since LMP:	Yes	No	
Chemical or other exposure:	Yes	No	

Medications, drugs, or alcohol use since last menstrual period: Yes No

If yes, list all medications- prescription, OTC (over-the-counter), including medications prescribed by VWCA doctors; drugs, and alcohol. _____

Genetic History

Patient's Age over 35 years: Yes No **(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			

INFORMATION COMPLETED BY: _____ ***DATE:*** _____

(Patient Signature)