NEW Patient -New OB Intake-

Name: ______________________________ DOB: ________________

Where did you receive pregnancy confirmation? Date?

____

Do you have a MY CHART account? ________________________

LMP:________________________

Drug allergies:

1. ________________
2. ________________
3. ________________
4. ________________

Preferred pharmacy:______________________________

Current medication list:

1.________________________
2.________________________
3.________________________
4.________________________
5.________________________
6.________________________

Past medical history:

1.________________________
2.________________________
3.________________________
4.________________________
5.________________________
6.________________________
7.________________________
8.________________________

Surgical history:

1.____________________________

2.____________________________

3.____________________________

4.____________________________

Family History:

Please circle all that apply and indicate which family member:

Breast cancer___________________________________

Ovarian cancer___________________________________

Diabetes____

Heart Disease_____________________________________

Colon Cancer_____________________________________

Tobacco Use or smokeless tobacco:

Please circle:

Current smoker:

Type:_________________________________

How many packs a day?___________________

Never

Former smoker:

Quit date:______________________________

Drug use:____________________________________

Types:_______________________

Alcohol use:__________________________________

Drinks per week:____________________

OB history:

How many times have you been pregnant?____________

History of miscarriage? ___________________________

Date:____________________

D&C required? ________________________

History of Elective abortion? _______________________

Date:______________________________

Ist pregnancy:

Date of delivery: ____________________ Full term or preterm

Gestational Age: _____________________

Delivery type: _______________________

Birth weight: ________________________

Pre- term Labor: _____________________

Sex: _______________________________

Labor complications:_________________________________

2nd pregnancy:

Date of delivery:__________________________ Full term or preterm

Delivery type: ____________________________

Gestational Age: ___________________________

Birth weight: ______________________________

Pre- term Labor: ___________________________

Sex: _____________________________________

Labor complications:________________________

3rd pregnancy:

Date of delivery:______________________________ Full term or preterm

Delivery type: ______________________________

Gestational Age: ______________________________

Birth weight: ______________________________

Pre-term Labor: ______________________________

Sex: ______________________________

Labor complications:______________________________

If more than 3 pregnancies, please use back of sheet

Which OB provider would you prefer to see? ______________________________

Family Genetic History

Please circle all that apply.

Thalassemia

Down's syndrome

Tay Sach

Sickle Cell

Hemophilia

Muscular Dystrophy

Cystic Fibrosis

Huntington's disease

Mental Retardation

Fragile X

Chromosomal Disease

Birth Defect

Greater than 3 Abortions

History of stillborn

None

Infection Screening

Please answer yes or no.

Vaccinated against chicken pox or history of chicken pox? ______________________________

History of Hepatitis B vaccine? ______________________________

Exposure to Tuberculosis? ______________________________

History of genital herpes (HSV) _ ______________________

Partner with history of genital herpes (HSV) ________________________________

History of sexual transmitted infection: ________________________________

Name of infection____

Date______________________________

Exposure to cat litter_________________________

History of fifth disease________________________

Occupational exposure to children____________________________________

Your weight prior to pregnancy? ____

Since pregnancy have you noticed any vaginal bleeding or discharge?____

Questions or concerns for the nurse today? Please list below. Questions will be addressed at the **end** of the visit. Please note, some concerns will have to be addressed with the provider at your new ob physical exam. Thank you.

1.____

____

2.____

____

3.____

____

4.____

____