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Obstretrical Patient In-take Questionaire

Please fill out this form as completely as possible and bring it to your nurse in-take appointment scheduled for:_____ at _____

PATIENT INFORMATION

First Name:_____ MI:____ Last Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____
DOB:_____ Marital Status:_____ Race:_____
Occupation:_____ Work Phone:_____
Insurance:_____ Policy #:_____
Referring Physician:_____ Hospital of Delivery:_____
Newborn's Physician: _____

CONTACTS

Husband:_____ Phone:_____
Father of Baby:_____ Phone:_____
Emergency Contact:_____ Phone:_____

PREGNANCY INFORMATION

Total Pregnancies:____ Full Term Pregnancies:____ Premature Pregnancies:____
Ectopic:___ Ab. Induced:___ Ab. Spontaneous:___ Multiple Births:___ Living:____

MENSTRUAL HISTORY

Last Menstrual Period:_____ Menses Monthly? Yes O No O
O Unknown O Definite O NI/amt/duration O Approx (month known)
Duration of menses: _____ Menarche (Age Onset):_____
Prior Menses:_____
On BCP at conception? Yes O No O hCG + :_____

PAST PREGNANCIES (Last six entered from left to right)

Date:	_____	_____	_____	_____	_____	_____
GA weeks:	_____	_____	_____	_____	_____	_____
Labor length:	_____	_____	_____	_____	_____	_____
Birth weight:	_____	_____	_____	_____	_____	_____
Gender:	_____	_____	_____	_____	_____	_____
Delivery type:	_____	_____	_____	_____	_____	_____
Anesthesia:	_____	_____	_____	_____	_____	_____
Place of delivery:	_____	_____	_____	_____	_____	_____
Preterm labor:	_____	_____	_____	_____	_____	_____
Comments/ Complications:	_____	_____	_____	_____	_____	_____
General Comments:	_____	_____	_____	_____	_____	_____

MEDICAL HISTORY

	Date(s)	*Comments*
Diabetes		
Hypertension		
Heart Disease		
Autoimmune disorder		
Kidney disease / UTI		
Neurological / Epilepsy		
Psychiatric		
Postpartum / Depression		
Hepatitis / Liver disease		
Varicosities / Phlebitis		
Thyroid Dysfunction		
Trauma / Violence		
Hx of Blood Transfusion		

		Amt/d Pre-Preg.	Amt/d Preg.	# Yrs Use
Tobacco				
Alcohol				
Illicit/Recreational Drugs				

D(Rh) Sensitized	
Pulmonary (TB, Asthma)	
Allergies (Seasonal)	
Allergies (Drug/Latex)	
Breast	
Gynecological Surgery	
Operations / Hosp.	
Anesthetic Complications	
Abnormal Pap History	
Uterine Anomaly / DES	
Infertility/ART Treatment	
Relevant Family History	
Other	

Other Comments: _____

Symptoms: _____

SYMPTOMS SINCE LAST MENSTRUAL PERIOD

Symptoms: _____

Comments: _____

_____

GENETIC SCREENING / TERATOLOGY COUNSELING

Includes Patient, baby's father, or anyone in either family with these conditions

Patient older than 35 years old? O No O Yes _____
Thalassemia? (Italian, Greek, Mediterranean or Asian background; MVC < 80)
O No O Yes _____
Neural Tube Defect? (meningomyelocele, spina bifida, or anencephaly)
O No O Yes _____
Congenital Heart Defect? O No O Yes _____
Down Syndrome? O No O Yes _____
Tay-Sachs? (e.g. Jewish, Cajun, French Canadian) O No O Yes _____
Canavan Disease or Familial Dysautonomia? (Ashkenazi Jewish)
O No O Yes _____
Sickle Cell Disease or Trait? (African) O No O Yes _____
Hemophilia or other Blood Disorders? O No O Yes _____
Muscular Dystrophy? O No O Yes _____
Cystric Fibrosis? O No O Yes _____
Huntington's Chorea? O No O Yes _____
Mental Retardation? O No O Yes _____
If yes, was the person tested for fragile X? O No O Yes _____
Other Inherited Genetic or Chromosomal Disorder? O No O Yes _____
Maternal Metabolic Disorder? (i.e. Type 1 Diabetes, PKU) O No O Yes _____
Patient or baby's father had a child with birth defects not listed above?
O No O Yes _____
Recurrent pregnancy loss or a stillborn? O No O Yes _____
Medication/Street drugs/Alcohol since LMP? O No O Yes _____
If yes, agent(s) _____
Autism? O No O Yes _____
Any Other? _____
Comments/Counseling _____

INFECTION HISTORY

Hepatitis B, C, or high risk? O No O Yes Immunized? O No O Yes _____
Live with someone with TB or exposed to TB? O No O Yes _____
Patient or partner has history of genital herpes? O No O Yes _____
Rash or Viral Illness since LMP? O No O Yes _____
History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis? O No O Yes
Other _____

Comments: _____
_____
_____

ADDITIONAL INFORMATION

Drug allergies? O No O Yes
If yes, which drugs? _____
_____
_____

Latex allergy? O No O Yes _____

Is blood transfusion acceptable in an emergency? O No O Yes _____

MEDICATION LIST

Please provide a complete list of all medications including dates and dosage:

_____
_____
_____
_____
_____
_____
_____

PROBLEMS

Please provide information regarding any problem(s) not previously noted

_____
_____
_____
_____
_____

Patient's signature: _____ Date: _____