



Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

Are you new to our clinic, if yes where have you been seen before? \_\_\_\_\_  
Who is your primary care physician? \_\_\_\_\_  
Are you allergic to any medications? \_\_\_\_\_  
Are you allergic to Latex? \_\_\_\_\_

**Immediate Concerns**  
Are you currently having any vaginal bleeding? \_\_\_\_\_  
Are you currently experiencing any significant abdominal pain/cramping? \_\_\_\_\_  
Do you have a history of ectopic pregnancies? \_\_\_\_\_  
Do you have diabetes? \_\_\_\_\_  
Do you have any other chronic medical condition that requires medication? \_\_\_\_\_

**OB Initial Intake Information**  
When did you get a positive pregnancy test and where was it done? \_\_\_\_\_  
What is your race? \_\_\_\_\_  
What is your marital status? \_\_\_\_\_  
What is your occupation? \_\_\_\_\_  
What is the last grade completed? \_\_\_\_\_  
Number of children at home? \_\_\_\_\_  
What is your hospital of delivery for this pregnancy? \_\_\_\_\_  
Who is your newborn's Physician? \_\_\_\_\_

**Father of Baby Information**  
The father of baby's name? \_\_\_\_\_  
Father of your baby's occupation? \_\_\_\_\_  
Phone number for Father of baby? \_\_\_\_\_  
Anything else that we should know about Father of baby? \_\_\_\_\_

**Menstrual History**  
What was the 1st day of last menstrual period (LMP)? \_\_\_\_\_  
Was it on time? \_\_\_\_\_  
Are you sure of the date? \_\_\_\_\_  
Age at 1st menstruation? \_\_\_\_\_  
Days of flow? \_\_\_\_\_  
How often do you get your period? Every how many days? \_\_\_\_\_  
Pre-pregnancy weight? \_\_\_\_\_  
Symptoms since LMP? \_\_\_\_\_  
Do you have severe pain with periods? \_\_\_\_\_  
Do you have extremely heavy periods? \_\_\_\_\_

**Pregnancy History**

How many previous pregnancies have you had (including miscarriages and abortions)? \_\_\_\_\_  
 For each pregnancy what was the Hospital, number weeks pregnant, type delivery (vaginal/C-section),  
 birth weight, sex, any complications? \_\_\_\_\_  
 \_\_\_\_\_

**Medical History**

Do you currently have or have you ever had kidney or bladder problems, urinary tract infections, or  
 cystitis? \_\_\_\_\_  
 Do you have or have you ever had ulcers, stomach problems or colitis? \_\_\_\_\_  
 Have you ever had infertility problems? \_\_\_\_\_  
 Do you currently have or have you ever had an abnormal pap smear or female or gynecological  
 problems? \_\_\_\_\_  
 Do you currently have or have you ever had heart disease? \_\_\_\_\_  
 Do you currently have or have you ever had rheumatic fever? \_\_\_\_\_  
 Do you currently have or have you ever had high blood pressure? \_\_\_\_\_  
 Do you currently have or have you ever had epilepsy or seizures? \_\_\_\_\_  
 Do you currently have or have you ever had emotional concerns including depression? \_\_\_\_\_  
 Do you currently have or have you ever had thyroid problems? \_\_\_\_\_  
 Do you have any history of thyroid disorders? \_\_\_\_\_  
 Do you currently have or have you ever had diabetes? \_\_\_\_\_  
 Do you currently have or have you ever had varicose veins or blood clots in your legs? \_\_\_\_\_  
 Do you currently have or have you ever had bleeding tendencies? \_\_\_\_\_  
 Do you currently have or have you ever had broken bones or concussions? \_\_\_\_\_  
 Do you currently have or have you ever had autoimmune diseases? \_\_\_\_\_  
 Are you allergic to any medications? \_\_\_\_\_

**Past Surgical history**

Are you currently in need or have you ever had an operation? For each operation list date, type, place,  
 complications. \_\_\_\_\_  
 \_\_\_\_\_

**Family History**

Do any of your immediate family members have any of the following? If yes who?  
 Diabetes \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_  
 Heart Disease \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  
 High Cholesterol \_\_\_\_\_  
 Stroke/Blood Clot in legs/Blood clot in lungs \_\_\_\_\_  
 Thyroid Clotting disorder \_\_\_\_\_  
 Other Illness \_\_\_\_\_

**Social & Lifestyle History**

Do you smoke? How many cigarettes a day? \_\_\_\_\_

Do you chew? \_\_\_\_\_

Are you around anyone who does smoke? \_\_\_\_\_

Do you drink alcohol? How many times a day? \_\_\_\_\_

How many caffeinated drinks a day? \_\_\_\_\_

Have you used marijuana, LSD, speed, heroin, crystal, crack, cocaine? \_\_\_\_\_

What medicines, over the counter medicines, or recreational drugs have you taken since becoming pregnant (include all prescription and nonprescription drugs)? \_\_\_\_\_

Do you exercise, if yes how often? \_\_\_\_\_

How often do you wear your seatbelt? \_\_\_\_\_

How often do you get sun exposure? \_\_\_\_\_

**Genetic Screening**

Will you be age 35 yrs or older when the baby is due? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had Down Syndrome? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had any other chromosomal abnormality? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had neural tube defect (i.e. Spina Bifida)? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had anencephaly? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had hemophilia or other bleeding disorders? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had muscular dystrophy? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had multiple births? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had stillbirth? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had child with any other birth defect? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had Sickle Cell Disease/trait? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had cystic fibrosis? \_\_\_\_\_

Do you have Jewish/Ashkenazi background? \_\_\_\_\_

Have you, the baby's father, or anyone in either of your families ever had anything that was not mentioned above? \_\_\_\_\_

**Personal History**

Have you ever had a major accident? \_\_\_\_\_

Have you ever had blood transfusion? \_\_\_\_\_

Do you have any piercings or tattoos? \_\_\_\_\_

Have you ever had an abnormal pap? \_\_\_\_\_

Have you ever had a uterine anomaly? \_\_\_\_\_

Have you ever had infertility? \_\_\_\_\_

Have you ever had DES exposure? \_\_\_\_\_

Have you ever had liver disease or hepatitis? \_\_\_\_\_

Have you ever had varicosities? \_\_\_\_\_

Have you ever had phlebitis? \_\_\_\_\_  
Have you ever had Thyroid Dysfunction? \_\_\_\_\_  
Have you ever had Physical Abuse? \_\_\_\_\_  
Have you ever had Sexual Abuse? \_\_\_\_\_

**Infections and environmental exposures**

Do you currently have or ever had or been exposed to tuberculosis? Have you ever lived with anyone who had tuberculosis? \_\_\_\_\_

Do you currently have or ever had or been exposed to a sexual transmitted disease, including Chlamydia, herpes, gonorrhea, syphilis, genital warts, HPV or HIV? \_\_\_\_\_

Do you currently have or ever had since your last menstrual period a rash, viral or febrile illness or fever? \_\_\_\_\_

Do you live in a house with cats? \_\_\_\_\_

Do you currently have or ever had or been exposed to hepatitis? \_\_\_\_\_

Do you currently have or ever had chicken pox? \_\_\_\_\_

With this pregnancy have been exposed to an x-ray? \_\_\_\_\_