



**OB INTAKE PATIENT INFORMATION**

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

Patient Identification

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Phone numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_

**PREGNANCY DATING:**

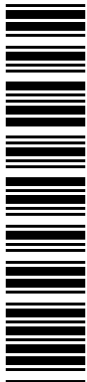
First day of last menstrual period: \_\_\_\_\_  Certain  approximate? (Select one)  
Tracking ovulation:  Yes  No If yes, date of ovulation: \_\_\_\_\_ Method of tracking: \_\_\_\_\_  
Did you use fertility treatment to achieve this pregnancy?  Yes  No **Which** method? \_\_\_\_\_  
Were you on birth control when you became pregnant?  Yes  No **Which** method? \_\_\_\_\_

**PAST MEDICAL AND FAMILY HISTORY:**

*For yourself, provide details and dates. For family members, please check if yes. In the 'other' column, please specify who the family member is, such as: Maternal Grandmother (MGM), Maternal Grandfather (MGF), Paternal Grandmother (PGM), or Paternal Grandfather (PGF).*

Check here if you were adopted

	Self	Mother	Father	Sister	Brother	Child	Other
Alcoholism							
Arthritis							
Asthma							
Anxiety							
Bleeding Disorder: Please specify							
Bowel Problems: Please specify							
Cancer: Please specify							
Chickenpox							
Depression							
Diabetes							
Drug Abuse							
Eating Disorder: Please specify							
Emphysema							
Heart Disease							
Heartburn							
Hepatitis: Please specify							
High Blood Pressure							
High Cholesterol							
Osteoporosis							
Seasonal Allergies							
Stroke							
Thyroid Disease							
Ulcer:							
Other							
Other							



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**SURGICAL HISTORY**

List any surgeries you have had: (i.e. wisdom teeth removal)

Date

_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY**

***Tobacco Use:***

Any form of tobacco use past or present (cigarettes or smokeless tobacco):  Yes  No  
 Current use:  Yes  No How many packs per day: \_\_\_\_\_ Number of years: \_\_\_\_\_  
 Are you interested in quitting or desire tobacco cessation information?  Yes  No  
 Past use:  Yes  No Number of years: \_\_\_\_\_ Quit date: \_\_\_\_\_  
 Other tobacco use:  Pipe  Cigar  Snuff  Chew  Never

***Alcohol Use:***

Do you drink alcohol?  Yes  No # of drinks per week: \_\_\_\_\_  
 Quit for pregnancy?  Yes  No

***Drug Use:***

Do you use marijuana or other recreational drugs?  Yes  No  
 Have you ever used needles to inject drugs?  Yes  No

***Sexual Activity:***

Currently sexually active?  Yes  No If yes, partner's name: \_\_\_\_\_  
 Sexual partner(s) is/are/have been:  Male  Female  Both

**Activities of Daily Living:**

1. Have you ever served in the military?  Yes  No
2. Have you ever had a blood transfusion?  Yes  No
3. Do you have any concerns about caffeine?  Yes  No
4. Do you have any occupational exposures (chemicals, x-rays, chemo, etc)?  Yes  No
5. Do you participate in any extreme or hazardous hobbies?  Yes  No
6. Do you have any sleep concerns?  Yes  No
7. Are you currently experiencing any unusual stressors?  Yes  No
8. Do you have any weight concerns?  Yes  No
9. Do you eat a special diet such as vegetarian or gluten-free?  Yes  No \_\_\_\_\_
10. Do you have any previous back injuries or scoliosis?  Yes  No
11. Do you exercise?  Yes  No If so, what do you do for exercise? \_\_\_\_\_
12. Do you wear a helmet when riding a bicycle?  Yes  No
13. Do you wear a seatbelt in the car?  Yes  No
14. Do you do self-breast exams?  Yes  No



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**Social/Safety Documentation:**

1. Who do you live with? \_\_\_\_\_
2. Do you have any cats in your home?  Yes  No  
If yes, who cleans the litter box? \_\_\_\_\_
3. Do you have working smoke alarms?  Yes  No
4. Are there any guns in the home?  Yes  No  
If yes, are they locked up or secured? \_\_\_\_\_
5. Do you have a religious preference? \_\_\_\_\_
6. Would you agree to a blood transfusion if needed?  Yes  No
7. What is your racial ethnicity: \_\_\_\_\_
8. Primary language: \_\_\_\_\_
9. How many years of education do you have? \_\_\_\_\_  
Type of Degree (if applicable) \_\_\_\_\_
10. What is your occupation? \_\_\_\_\_
11. What is your partner's occupation? \_\_\_\_\_
12. Has there been a history of violence, trauma, or physical, sexual, or emotional abuse in your family, or in your relationship (past or present)?  Yes  No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OBSTETRIC HISTORY**

*Check here if you have never been pregnant*

Please list all pregnancies in order (from oldest to most recent). For pregnancy outcome, please list type of delivery: **Term** (37+ weeks), **Pre-term** (< 37 weeks), **Miscarriage**, **Abortion**, or **Ectopic Pregnancy**. If you need more room, please use the back of the form. **For history of C-section, please provide reason.**

Pregnancy Outcome	Date of Delivery	# of weeks	Labor Length	Baby's Weight	Sex (M/F)	Delivery Type (Vag or C/S)	Epidural/ IV med/ None	Living/ (Y/N)/ Name	Delivery location/ complications during pregnancy or delivery/ reason for C-section
1.									
2.									
3.									
4.									
5.									
6.									



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**GYNECOLOGIC HISTORY**

- Age of first period: \_\_\_\_\_
- First day of last menstrual period: \_\_\_\_\_
- Are your periods regular?  Yes  No
- How often do you have your period: Every \_\_\_\_\_ days
- How long does your period last: \_\_\_\_\_ days
- Date of last pap smear: \_\_\_\_\_ Result: \_\_\_\_\_
- Have you ever had an abnormal pap smear:  Yes  No Please list year and treatment for each abnormal pap: \_\_\_\_\_  
\_\_\_\_\_
- History of sexually transmitted infections?  Yes  No If yes, type(s); \_\_\_\_\_

**SOCIAL DATA/HABITS/EXPOSURE**

- Spouse/Partner's Name: \_\_\_\_\_
- Was this a planned pregnancy?  Yes  No
- Are you considering placing baby up for adoption?  Yes  No
- Tobacco Cessation information needed?  Yes  No
- HIV testing is performed as a standard of care and will be drawn with your prenatal labs in each pregnancy. If you have concerns, please discuss this with your provider.
- Will you be 35 or over at time of delivery  Yes  No

**GENETIC HISTORY:** For any positive answers, **please list the affected family member**

	Your Family	Partner's Family	Negative
Sickle Cell Disease or Trait (African)			
Thalassemia (Italian, Greek, Medit. or Asian)			
Tay-Sachs Disease (Jewish, Cajun, French Canadian)			
Down Syndrome			
Developmental Delay, Mental Retardation, or Autism			
If yes, was the person tested for Fragile X?			
Neural Tube Defects (Spina Bifida, Meningocele, or Anencephaly)			
Cystic Fibrosis			
Huntington's Chorea			
Muscular Dystrophy			
Hemophilia			
Definite/ Probable ADD/ADHD			
Other chromosomal abnormality or genetic disorders?			
Previous pregnancy and/or child with birth defect(s)?			



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**MEDICATION LIST/PREFERRED PHARMACY**

Please list all medications, vitamins, and supplements you are currently taking or have been prescribed: Please list additional medications on the back of this form.

Name of Medication/vitamin/supplement	Dosage	How often do you take it?
1.		
2.		
3.		
4.		
5.		
6.		

What is your preferred pharmacy? \_\_\_\_\_

Location: \_\_\_\_\_

**ALLERGIES:**      No known drug allergies   

**List Medications/Food/Latex Allergy:**

**Reaction**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other information you wish to share with your provider:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_