Pregnancy Intake Form

Patient Name: ___________________________ D.O.B: _______________ Date: _________________

Address: Street___________________________ City _______________ ST ___________ Zip ____________

Home Phone: ________________________________ Cell/Work: _________________________________

Insurance: ___________________________________ Secondary: ________________________________

PREGNANCY HISTORY: **LAST PERIOD**: ____________________

Number of pregnancies (including this one) ___________ Number of live births: ________________

Number of miscarriages: __________ Any pregnancy losses after 4 Months? Yes ____ No _____

Have you had any Tubal (Ectopic) Pregnancies? Yes______ No_____

Have you had any Molar Pregnancies? Yes______ No_____

Have you had or are you having any bleeding? Yes______ No_____ Cramping? Yes_____ No____

MEDICAL ISSUES:

Have you had chicken pox? Yes_______ No ________

Do you currently have diabetes? Yes_______ No ________

Have you ever had diabetes in pregnancy? Yes_______ No ________

Do you have a seizure disorder/epilepsy? Yes_______ No ________

Do you have hypertension or history of gestational hypertension? Yes_______ No________

Do you have thyroid disease? Yes_______ No________

Any family history of Spina Bifida? (If so, give 4mg Folic Acid QD extra) Yes_______ No ________

Are you on Methadone/Suboxone/Subutex? Yes_______ No ________

Do you or have you used cocaine, heroin, or other street drugs? Yes_______ No________

Do you have HIV/AIDS/Hepatitis B/Hepatitis C? Yes_______ No ________

Do you have high blood pressure? Yes_______ No ________

Do you smoke? Yes_______ No ________

Do you drink alcohol? Yes_______ No ________

Have you had gastric bypass surgery? Yes_______ No ________

Are you allergic to any medications? Yes_______ No ________

If yes, please list: ____

Are you taking any medications? Yes_______ No ________

If yes, please list: ____

Are you or your partner? Black_____ Hispanic _____ Asian ______ (screening for Sickle Cell disease)

Do you work with young children? Yes_______ No ________

STAFF USE ONLY

Weight: ___________ Height: ___________ BMI: ___________ Test: pos_______ Date: __________

______ Patient was advised to discontinue drinking, smoking, and/or drug use during pregnancy.

______ Prenatal vitamins given: ____

______ Patient was advised of importance of taking prenatal vitamins.

______ Patient was given list of OTC medications.

Nurse Interview________________________________ 1st OB appt:_______________________________

Number of weeks @ 1st OB: ____________________ STAFF SIGNATURE:_________________________