Valley Care Clinics

The care you need, when you need it

OB INTAKE FORM

Patient's Name (PLEASE PRINT): _____DOB_____AGE_____

Husband/Father of Baby:_____AGE_____Phone #_____

Pharmacy of Choice and Location:_____Phone_____

When was your last PAP smear? _____Was it Normal ☐Yes ☐No

Please check past treatments required ☐LEEP ☐Conization ☐Cryotherapy

Last menstrual period _____ Was it Normal ☐ Yes ☐ No

Were you using Birth Control Pills or an IUD when you became pregnant? ☐Yes ☐No If yes which one_____

MENSTRUAL HISTORY

Last Menstrual Period: Date_____ ☐Definite ☐Approx. (Month Known) ☐Unknown

Menses Monthly ☐Yes ☐No Frequency: Every ____days ☐Home preg test pos ___/___/_____

Age of first menstrual Cycle:_____

ALLERGIES

DRUG	REACTION

DRUG	REACTION

Are you allergic to Shellfish, Iodine, Penicillin or Latex?
(Circle if you are)

MEDICATIONS

What medications you have taken during this pregnancy. (Including birth control pills and drugs you buy without a prescription).

DRUG	DOSAGE

DRUG	DOSAGE

DRUG	DOSAGE

PAST MEDICAL ILLNESSES (have you been treated for any of these))

YES	NO	
		Irregular Heart Beat
		Congestive Heart Failure
		Heart Murmur
		Rheumatic Fever
		Any other Heart Condition
		Blood Clot in Leg, Lung or varicose veins
		High Cholesterol
		High Blood Pressure
		Heart Murmur
		Rheumatic Fever
		Asthma
		Emphysema / Chronic Bronchitis
		Blood Clot in Lung
		Tuberculosis
		Gallstones
		Liver Disease, Including Hepatitis
		Ulcers in Bowels/Stomach
		Kidney Disease, Type:
		Genital Herpes, Genital Warts, Other

YES	NO	
		Kidney Stones
		Chicken Pox (Have you had it)
		Sickle Cell Disease/Trait
		Arthritis
		Skin Disease, Type:
		Stroke
		Epilepsy / Seizures
		Migraine Headache
		Diabetes / High Blood Sugar
		Thyroid Problems – too high or too low
		Anemia / Low Blood
		Bleeding Problems Type:
		Blood Transfusion
		Cancer, Type:
		Anxiety or Depression
		Psychological Problems
		Sexually Transmitted Disease-If YES please
		Please circle: HIV, Chlamydia, Gonorrhea, syphilis,
		Infertility Treatments

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Number of Pregnancies ____ Number of Deliveries ____ Number of Elective Abortions ____ Number of Miscarriages ____

Date/Hospital	# Weeks Pregnant	Infant Weight	Vaginal/C-Section	Hrs in labor	Epidural Yes or No	Any problems?

Please check if you had any of these conditions during your pregnancy/pregnancies: ☐**Increased Blood Pressure** ☐**"Toxemia"** ☐ **Preterm Labor** ☐**Abruption** ☐**Gestational Diabetes**

PAST SURGERIES YOU HAVE HAD

YES	NO	SURGERY	DATE
		Appendectomy	
		Joint Scope Surgery	
		Biopsy of:	
		Open Heart Surgery	
		Neck Artery Surgery	
		Eye Surgery, R L	
		Gallbladder	
		Broken Bone Repair	

YES	NO	SURGERY	DATE
		Joint Replacement	
		Back Disc Surgery	
		Abdominal Surgery	
		Tonsils Removed	
		Wisdom Teeth Extraction	
		D&C	
		Vaginal Surgery	
		Other:	

OTHER SPECIALTY DOCTORS YOU SEE

SPECIALTY	NAME	LOCATION	PHONE #

YOUR FAMILY HISTORY AND FATHER OF THE BABY FAMILY

(Disease affecting your parents, grandparents, brothers and sisters only.) Please note the person.

YES	NO	Who?
		Heart Attack
		High Blood Pressure
		High Cholesterol
		Asthma
		TB Family member or household contact
		Liver Disease
		Kidney Disease
		Birth defects
		Stroke
		Epilepsy / Seizures

YES	NO	Who?
		Bleeding Problems
		Sickle Cell Anemia
		Diabetes / High Blood Sugar
		Thyroid Problems
		Cancer, Type:
		Cancer, Type:
		Infant surgery
		Anxiety or Depression
		Infant Death, stillborn, Birth defect(please circle)
		Other:

Add any details about anything else you want your doctor to know: _____

_____

_____

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SOCIAL HISTORY

Smoking:

Have you ever smoked: __Yes ___No How many years did you smoke? _____

How many packs per day do you smoke now: _____ Do you plan on stopping for this pregnancy?: __Yes __No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Illicit/Recreational Drugs:

__Yes __No In the last year, have you ever drunk alcohol or used drugs more than you meant to?

What drugs have you used in the past? _____

What drugs do you currently use? _____

How often do you use caffeine a day? _____ Do you have any indoor cats?_____

Please Check one

Do you plan to: ☐Breast Feed ☐Bottle Feed ☐Undecided

Do you want an Epidural? ☐ Yes ☐ No ☐Undecided

Please tell me how you feel about this pregnancy. (happy, disappointed, confused, traumatized, etc) Do you need to talk to someone about other pregnancy options or counseling for this pregnancy?

_____

Genetic Screening/Teratology Counseling

Includes Patient, Baby's Father, or anyone in either family

	Circle Correct Answer		Circle Correct Answer
Patients age 36 years or older as of estimated date of Delivery	**Yes No**	Huntington's Chorea	**Yes No**
Thalassemia, (Italian, Greek, Mediterranean, or Asian background) MCV les than 80	**Yes No**	Mental Retardation/Autism If YES, was person tested for Fragile X?	**Yes No** **Yes No**
Neural Tube Defect(Meningomyelocele, Spina Bifida, or Anencephaly)	**Yes No**	Other inherited Genetic or Chromosomal disorder	**Yes No**
Congenital Heart Defect	**Yes No**	Maternal Metabolic Disorder(Ex: Type 1 diabetes, PKU)	**Yes No**
Down Syndrome	**Yes No**	Patient or Baby's father had a child with birth defects not listed above	**Yes No**
Tay-Sachs(Ashkenazi Jewish, Cajun, French Canadian)	**Yes No**	Recurrent Pregnancy loss or a stillborn	**Yes No**
Canavan Disease(Ashkenazi Jewish)	**Yes No**	Medications(including supplements, vitamins, herbs, or OTC drugs) Illicit/Recreational drugs/Alcohol since last menstrual period If YES List Drugs and Strength/Dosage	**Yes No**
Family Dysautonomia(Ashkenazi Jewish)	**Yes No**		
Sickle Cell Disease or Trait(African)	**Yes No**		
Hemophilia or other blood disorders	**Yes No**		
Muscular Dystrophy	**Yes No**		
Cystic Fibrosis	**Yes No**	Any Other	**Yes No**

Accurate information is critical to your care. We will make every effort to safeguard your information.

Thank you for helping us to serve you.

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INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HEPATITIS B,C		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS (CIRCLE ALL THAT APPLY)		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD IF YES WHICH ONE: _____			6. OTHER (SEE COMMENTS)		

COMMENTS

_____

_____

_____

PHYSICIAN ONLY

INITIAL PHYSICAL EXAMINATION

DATE ____/____/____ WEIGHT _____ HEIGHT _____ BMI _____ B/P _____ PULSE _____ TEMP _____

1. HEENT	□ NORMAL	□ ABNORMAL	12. VULVA	□ NORMAL	□ CONDYLOMA □ LESIONS
2. FUNDI	□ NORMAL	□ ABNORMAL	13. VAGINA	□ NORMAL	□ INFLAMMATION □ DISCHARGE
3. TEETH	□ NORMAL	□ ABNORMAL	14. CERVIX	□ NORMAL	□ INFLAMMATION □ LESIONS
4. THYROID	□ NORMAL	□ ABNORMAL	15. UTERUS SIZE	____WKS	□ FIBROIDS
5. BREAST	□ NORMAL	□ ABNORMAL	16. ADNEXA	□ NORMAL	□ MASS
6. LUNGS	□ NORMAL	□ ABNORMAL	17. RECTUM	□ NORMAL	□ ABNORMAL
7. HEART	□ NORMAL	□ ABNORMAL	18. DIAGONAL CONJUGATE	□ REACHED	□NO _____CM
8. ABDOMEN	□ NORMAL	□ ABNORMAL	19. SPINES	□ AVERAGE	□ PROMINENT □ BLUNT
9. EXTREMITIES	□ NORMAL	□ ABNORMAL	20. SACRUM	□ CONCAVE	□ STRAIGHT □ ANTERIOR
10. SKIN	□ NORMAL	□ ABNORMAL	21. SUBPUBIC ARCH	□ NORMAL	□ WIDE □ NARROW
11. LYMPH NODES	□ NORMAL	□ ABNORMAL	22. GYNECOID PELVIC TYPE	□ YES	□ NO

COMMENTS(Number and explain abnormal)

_____

_____

_____

_____

_____

_____

_____**EXAM BY** _____