Women's Health Center OB Intake
225 S. Union Blvd. 2nd floor

Form # MED50 eng
Form Date: 08/29/18

Name (Printed):_____ DOB:_____

Country of Birth:_____ Education Completed (years):_____

Occupation:_____ Religion:_____

Name of Father of the Baby (FOB):_____ Age of FOB:_____

Name of Support Person (Printed):_____

Have you had prenatal (pregnancy) care elsewhere? ☐ Yes ☐ No

If yes, when?_____

Since finding out you were pregnant, have you:

Had any visits to the Emergency Room (ER)? ☐ Yes ☐ No

Had any ultrasounds? ☐ Yes ☐ No

Is anything worrying you today? ☐ Yes ☐ No

If yes, please explain:_____

_____

Have you experienced any problems since you became pregnant? ☐ Yes ☐ No

If yes, please explain:_____

_____

Please list allergies to medications:_____

_____

Please list current medication list:_____

_____

Pregnancy History

First day of last menstrual period:_____

Was it normal? ☐ Yes ☐ No

Do you have a period every month? ☐ Yes ☐ No

Were you on birth control at conception? ☐ Yes ☐ No

How many:

Pregnancies:_____ Living Children:_____

Full-term deliveries (37+ weeks):_____ Premature deliveries (20-36 weeks):_____

C-section:_____ Vaginal delivery:_____

Multiples (twins):_____ Abortions:_____

Miscarriages:_____ Ectopic:_____

Personal Pregnancy Record

1. DATE	2. WEEKS	3. HOURS IN LABOR	4. BIRTH WEIGHT	5. SEX	6. TYPE OF DELIVERY	7. ANESTHESIA	8. LOCATION	9. PRETERM LABOR (<36 wks)	10. COMPLICATIONS
1/1/2001	***40***	***13***	***6.12***	***M***	***Vaginal***	***Epidural***	***UCH***	***No***	***N/A***

Patient's Health History

In the following chart below, please mark 'YES' or 'NO' if you have any disorders in the following areas. (This does not include family history or baby's father's history or baby's father's family history)

Disease	Yes	No	Disease	Yes	No
Diabetes			RH Negative		
High Blood Pressure			Pulmonary Disease (Tuberculosis/Asthma)		
Heart Disease			Seasonal Allergies		
Autoimmune Disorders			Breast Problems		
Kidney Disease/Urinary Tract Infections			Gynecological Surgeries		
Neurological Problems/Epilepsy			Operations/Hospitalizations		
Psychiatric Problems			Problems with Anesthesia		
Depression/Post-partum Depression			History of Abnormal Pap Smear		
Hepatitis/Liver Disease			Uterine Abnormalities/DES		
Varicosities/Phlebitis			Infertility		
Thyroid Dysfunction			Undergone Fertility Treatment		
History of Trauma or Violence			Patient Family History with Diabetes, Cancer, High Blood Pressure or Heart Disease		
History of Blood Transfusion					

Questions: Mark 'Yes' or 'No'	**Yes**	**No**
Do you live with someone with Tuberculosis (TB) or exposed to TB?		
Do you or a partner have a history of genital warts?		
Rash or viral illness since last menstrual period?		
History of Hepatitis B or C?		
History of sexually transmitted infection; HPV, Genital Warts, Syphilis, Gonorrhea, Chlamydia or HIV?		
History of Methicillin Staphylococcus Aereus (MRSA)?		

In the following chart below mark either 'Yes' or 'No' if a family history is present in these areas. This includes the baby's father's family and your blood related family.	**Yes**	**No**
Will you be 35 years of age or more at the time of delivery?		
Thalasemia		
Neural Tube Defects (Spina Bifida, Anencephaly)		
Congenital Heart Defects (major heart surgery at young age)		
Down Syndrome		
Tay-Sachs		
Canavan Disease		
Familial Dysautonomia		
Sickle Cell Anemia (disease or trait)		
Hemophilia or Blood Disorders		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Mental Retardation/Autism		
Other Inherited Genetic or Chromosomal Disorders		
Maternal Metabolic Disorders (PKU, Type I Diabetes)		
Patient or Father of Baby with Baby Born with Birth Defect		
Patient or Family History of 3 or more Miscarriages or 1 Stillbirth		