

Obstetrical Intake

Patient Information:

Name: _____ Date of Birth: _____

Marital/Partner Status: _____ Occupation: _____

Height: _____ Weight: _____

Partner's Name: _____ Partner's Occupation: _____

Partner's Phone Number: _____

Can we discuss your pregnancy with your partner? Yes No

Menstrual & Conception History:

Do you know the date your last menstrual period (LMP) started? Yes No

If yes, date (MM/DD/YYYY): _____

Was your last period normal? Yes No - If no, please explain: _____

Conception Method:

Spontaneous IVF IUI PGD Donor Egg Donor Sperm

Pregnancy confirmed by: Home test HCG blood test

Have there been any updates to your family medical history, or have you undergone any surgeries or hospitalizations since your last pregnancy? Yes No - If yes, please explain: _____

Birth Control History:

What birth control methods have you used?

OCP IUD Nexplanon Patch Other: _____

Current Pregnancy Symptoms:

Have you experienced any of the following since your last period?

Symptom	Yes	No	Please explain
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Viral Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	

Have you had any of the following conditions?

Condition	Yes	No	Condition	Yes	No
Abnormal Pap			Infertility		
Anxiety			Ovarian Cysts		
Autoimmune Disease			Seizure Disorder/Epilepsy		
Breast Disease			Syphilis		
Cancer			Thyroid Disease		
Chlamydia			Trichomonas		
Depression			Uterine Fibroids		
Diabetes			Hypertension		
Endometriosis			Elevated Cholesterol		
Genital Warts/HPV			PCOS		
Gonorrhea					
Heart Disease					
Herpes					

If so, please detail the year and how it was treated?

Pregnancy History:

Please note any history of preterm labor, pre-eclampsia, gestational diabetes, forceps/vacuum delivery, blood transfusion, hemorrhage, or prolonged hospital stay.

Date	Delivery Type	Birth Weight	Gender/Name	Complications

Total number of pregnancies:

_____ Vaginal deliveries _____ C-Section _____ Miscarriages _____ Abortions _____ Ectopic _____

Pregnancy or Postpartum Complications:

Has anyone in your family or your partner’s family had any of the following? If so, please include which family member(s).

Condition	Yes	No	Relation (if yes)
Intellectual Disabilities			
Autism/ADHD/Mental Retardation			
Birth Defects			
Congenital Heart Disease			
Cystic Fibrosis			
Down Syndrome			
Hemophilia			
Huntington’s Disease			
Muscular Dystrophy			
Sickle Cell Anemia			
Spina Bifida			
Thalassemia			
Unexplained Fetal Loss			
Other (please specify):			

Lifestyle & Mental Health

Medications, Allergies & Immunizations:

Current Medications (Rx, supplements, vitamins, herbs):

Allergies (environmental, food, medications): Yes No — If yes, specify: _____

Vaccination History:

Chickenpox: Had the illness Vaccinated

Up-to-date on: TDAP COVID Flu

Substance Use:

Tobacco: Yes No — Frequency: _____

Alcohol: Yes No — Frequency: _____

Drugs: Yes No — Type/Frequency: _____

Mental Health & Safety:

Any mental health concerns (e.g., anxiety, depression)? Yes No — If yes, details: _____

Do you have a support system (partner, family, friends)? Yes No

Do you see a therapist? Yes No

History of domestic violence or trauma? Yes No — Explain: _____

Do you feel safe at home? Yes No

Health & Exposure:

Would you accept a blood transfusion in a life-threatening situation? Yes No

Exposure to toxic work/environmental agents? Yes No — If yes, explain: _____

Any international travel (past 3 months):

You Yes No — Where/When: _____

Partner Yes No — Where/When: _____

Do you care for an indoor cat/litter box? Yes No

Genetic Testing:

Have you or the baby's father had genetic testing? Yes No — If yes, when: _____

If carrier positive, has the father been tested? Yes No

Have you seen a genetic counselor? Yes No — If yes, when: _____

Are you and the father blood related? Yes No

Pap Smear:

Do you remember your last Pap? Yes No

Date: _____ Result: _____