Patient Name_____

Date of Birth_____

Today's Date_____

PREGNANCY INTAKE FORM

We ask that you complete this form for each pregnancy. Some of these questions might be of a personal or sensitive nature, but we ask because they are important for the health of your baby. Leave blank anything you are unsure about and let your provider know you would like to discuss.

DUE DATE CALCULATION	
Date of last menstrual period? _____ Did your periods come regularly? ❑ Yes ❑ No Were you on birth control at the time of conception? ❑ Yes ❑ No Is this pregnancy a result of IUI or IVF? ❑ Yes ❑ No Have you had any ultrasounds yet? If yes, when and where?_____ Do you know a due date for this pregnancy? _____	

CONCERNS
Do you have any concerns you want to address with your provider today or about this pregnancy?

PARENT DETAILS	
Do you prefer a nickname?	Who is the father of this baby?
What is your race/ethnicity?	What is his date of birth?
What is your highest level of education?	What is his occupation?
What is your occupation?	What is his race/ethnicity?
What is your relationship to the baby's father?	What is his phone number?
Who would you like us to call in an emergency? Relationship? Phone Number?	

EXPOSURES	
Since last period have you…. ❑ Taken medications (prescription or OTC) ❑ Drank alcohol ❑ Used other drugs (marijuana, cocaine, etc) ❑ Smoked cigarettes ❑ Drank caffeine ❑ Been exposed to any other chemicals?	If yes to any, please explain….

PREVIOUS PREGNANCIES	
DATE	DETAILS *(miscarriage, D&C, live birth, cesarean, baby's weight, gender)*

Patient Name:_____ Date of Birth:_____

HISTORY

Do you have a personal history of: (Circle if yes)

Heart disease	Thyroid dysfunction	Breast Problems
Hypertension	Trauma / Violence	Gynecologic surgeries
Autoimmune disorder	History of Blood transfusion	Operations/Hospitalizations
Kidney disease / UTI	Rh (D) sensitization	Anesthetic Complications
Neurological / epilepsy	Pulmonary (Asthma, TB)	History of abnormal PAP smear
Depression / inc postpartum	Seasonal Allergies	Uterine anomaly or DES exposure
Hepatitis/ Liver disease	Allergies to medications	Infertility
Varicosities / Phlebitis	Allergy to Latex or adhesive	Diabetes
Gastrointestinal Problems		

If Yes, please explain:

GENETICS

Do you or the father of the baby, or any members of either family have: (Circle then explain below)

Thalassemia (Mediterranean anemia)	Hemophilia or other blood disorder	Down syndrome
		Sickle cell disease or trait
Neural Tube Defect	Muscular Dystrophy	Tay Sachs
Congenital heart disease	Cystic Fibrosis	Canavan disease
Mental retardation / Autism	Maternal metabolic disorder	Other inherited genetic or chromosomal disorder?
If yes, was tested for fragile X?	Child with other birth defects	
Recurrent pregnancy loss or stillbirth (explain)	Notes:	

Will you be over 35 when the baby is born? ❑ Yes ❑ No

INFECTION HISTORY

Have you been exposed to TB? ❑ Yes ❑ No

Do you <u>or your partner</u> have a history of?
- ❑ genital herpes?
- ❑ gonorrhea?
- ❑ history of chlamydia?
- ❑ history of syphilis?
- ❑ history of other STD?

Have you used injectable drugs? ❑ Yes ❑ No
Had a tattoo? ❑ Yes ❑ No
Other needle exposure? ❑ Yes ❑ No
We recommend all pregnant women be tested for HIV, please let us know if you refuse.

Do you have a history of MRSA, ESBL or other multi-drug resistant organism? ❑ Yes ❑ No
If yes, when and what site in your body?

Have you or the father of this baby travelled to an area with ZIKA virus? ❑ Yes ❑ No
If yes, when and where?

Have you had the chicken pox? ❑ Yes ❑ No

Do you own a cat? ❑ Yes ❑ No
Who changes the litter box?