PROVIDENCE
Medical Group
Women's Services

PATIENT LABEL

OBSTETRICS INTAKE FORM

Today's Date: _____

Name: _____DOB: _____ Age: _____ Preferred pronoun: She/He/They/Other_____

Occupation: _____ Partner's Name: _____ Partner's Gender: M / F / Other_____

Yes No

☐ ☐ Was this a planned pregnancy? If not planned, is this ok? ☐ Yes ☐ No

☐ ☐ Have you been seen by another doctor or ER in this pregnancy? If yes, was an ultrasound done? ☐ Yes ☐ No

☐ ☐ Would you accept a blood transfusion in a life threatening emergency?

Check box if you are currently experiencing any of the following?

☐ Nausea ☐ Headaches ☐ Cramping

☐ Vomiting ☐ Vision Changes ☐ Vaginal Bleeding

MEDICATION ALLERGIES/REACTION: _____

CURRENT MEDICATIONS: (prescription, over-the-counter, vitamins, herbals, and supplements)

Prenatal Vitamins ☐ Yes ☐ No _____

_____

Pharmacy Name AND Location _____

PAST OR CURRENT MEDICAL PROBLEMS: (Please check if YOU have or have ever had):

Do you change a cat's litter box? ☐ Yes ☐ No Have you had the Chicken Pox or Chicken Pox vaccine? ☐ Yes ☐ No

Yes No

☐ ☐ Abnormal pap
☐ ☐ Anemia
☐ ☐ Asthma/Allergies
☐ ☐ Anesthesia complications
☐ ☐ Arthritis / Bone / Muscle / Joint problems
☐ ☐ Breast problems or surgeries
☐ ☐ Cancer
☐ ☐ Diabetes or history of gestational diabetes
☐ ☐ Digestive / Stomach problems
☐ ☐ Genital Herpes (check if self or partner)
☐ ☐ Heart problems
☐ ☐ Headaches / Migraines
☐ ☐ HIV/AIDS
☐ ☐ High blood pressure
☐ ☐ Infertility

Yes No

☐ ☐ Kidney / Urinary disease
☐ ☐ Liver Disease / Hepatitis B or C
☐ ☐ Lupus / Rheumatoid arthritis
☐ ☐ Mental health concerns (e.g. anxiety/depression/bipolar/other)
☐ ☐ MRSA
☐ ☐ PCOS
☐ ☐ Postpartum depression
☐ ☐ Rh incompatibility
☐ ☐ Seizures
☐ ☐ Sickle cell anemia or trait
☐ ☐ STDs (e.g. gonorrhea /chlamydia / syphilis / other)
☐ ☐ Thyroid disease
☐ ☐ Trauma/Violence
☐ ☐ Tuberculosis or exposure to

*If **YES**, please describe and list any other health concerns*_____

_____

SURGERIES AND APPROXIMATE DATES (Month/Year): _____

_____

FAMILY HISTORY: (List blood-related family members with these conditions and relationship to the **PATIENT ONLY)**

Diabetes _____

High blood pressure _____

Kidney problems _____

Cancer (and type) _____

Twins (include family history of biological father) _____

Heart disease_____

Seizure disorders _____

Preterm labor/ miscarriages etc _____

Other significant family health concerns? _____

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SOCIAL HISTORY:

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

How many times in the past year have you had 4 or more drinks in a day? ☐ Never ☐ 1 or more
One drink = 12oz beer, 5oz wine, 1.5oz liquor (one shot)

How many times in the past year have you used a recreational drug OR used a prescription medication for nonmedical reasons? ☐ Never ☐ 1 or more ***Recreational Drugs*** *include methamphetamines, cannabis (marijuana/pot), inhalants (aerosols, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).*

Which statement best describes your **smoking status**?
☐ Never smoked ☐ Prior Smoker: Year quit: _____ ☐ Current Smoker: Packs / amount per day _____
Do you use vaping products? ☐ Yes ☐ No

Yes No
☐ ☐ Do you feel safe in your current relationship?
☐ ☐ Have you been hit, slapped, physically hurt or threatened by your partner?
☐ ☐ Is anyone misusing your money or property?

OBSTETRIC HISTORY:

 # Pregnancies _____ # Deliveries _____ # Miscarriages _____ # Abortions _____ # Ectopic _____
First day of last period: _____ Are your periods monthly? ☐Yes ☐No
Last pap smear: _____ ☐ Normal ☐ Abnormal
Pre-pregnancy weight: _____lbs Height: _____ft_____inches

Pregnancies: (Outcome is Vaginal, C-section, Miscarriage, Abortion or Ectopic)

						Child			
Date	Gestational Weeks	Hours of labor	Outcome	Epidural	Complications	Sex	Weight	Name	Living
/ /				☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /				☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /				☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /				☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /				☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /				☐Yes ☐No		☐F ☐M			☐Yes ☐No

GENETIC SCREENING: Do you or the biological father of the baby have any family history of the following? *Check box if **YES***

☐ Patient's Age 35 or older
☐ Thalassemia
☐ Neural Tube Defect
☐ Congenital Heart Defect
☐ Down syndrome
☐ Tay-Sachs
☐ Canavan Disease
☐ Familial Dysautonomia
☐ Sickle Cell
☐ Hemophilia / Blood Disorders
☐ Muscular Dystrophy
☐ Cystic Fibrosis
☐ Huntington's Chorea
☐ Intellectual Disability / Autism
☐ Fragile X
☐ Inherited Genetic/Chromosomal disorder
☐ Maternal Metabolic Disorders
☐ Baby's Father or Mother with Birth Defect
☐ Recurrent Pregnancy Loss or Stillbirth
☐ Other

*If **YES** to any of the above please explain* _____

*EMR Entry by*_____