sacramento women's health
an ob/gyn partnership

OB INTAKE FORM

Name:_____ Age:_____ Date:_____
Marital/Partner Status: _____ How Long: ____ Primary Care Doctor: _____
Your Occupation:_____ Partner's Occupation:_____
Name of father of child: _____ Age:_____
How did you hear about our office? _____

PERSONAL HEALTH HISTORY

Have you ever had an allergic reaction to medication? If yes, please list:_____ _____	☐Yes	☐No
Please list any surgery or hospitalization that you have had and the date:		
Please describe any health problems or symptoms that you are having at this time:		

Please mark any condition that you have or had in the past:

☐ Epilepsy	☐ Anemia	☐ Recurrent Urinary tract infections
☐ Headache	☐ Blood Transfusion	☐ Prior preterm labor
☐ Thyroid disorder	☐ Gastrointestinal disorder	☐ Frequent infections
☐ Breast disease	☐ Hepatitis	☐ Psychiatric illness
☐ Asthma disorder	☐ Kidney disease	☐ Von Willebrand disease or bleeding
☐ Tuberculosis	☐ Skin disorder	☐ Depression/Postpartum Depression
☐ Heart disease	☐ Herpes	☐ Sexually transmitted infections
☐ High blood pressure	☐ HIV/AIDS	☐ Diabetes (type 1 or type 2)
☐ Cancer	☐ Eating disorder	☐ Blood clotting disorder
☐ Gestational diabetes	☐ Arthritis or Lupus	☐ Group B Streptococcus in prior pregnancy
☐ Other_____		

Do you or any family member have a history of problems with anesthesia? If yes, please describe:_____ _____	☐Yes	☐No
Do you have any objections to any form of medical treatment (eg. Blood transfusion) If yes, please describe:_____ _____	☐Yes	☐No

MENSTRUAL AND PREGNANCY HISTORY		
Date of last menstrual period: _____ Age at first period: _____		
Are your periods regular? If yes, how may days apart: _____	☐Yes	☐No
Do you take medications for cramps? If yes, please list_____	☐Yes	☐No
Do you have hot flashes or night sweats? If yes, how often:_____	☐Yes	☐No

When was your last pap smear test? _____		
Have you ever had an abnormal pap test? If yes, when and how were you treated? _____ _____ What was the diagnosis? _____	☐Yes	☐No
Did you have any procedures on the cervix for treatment (eg. LEEP (loop electrosurgical excision procedure) or cold knife or laser conization?	☐Yes	☐No
Have you ever had HPV?	☐Yes	☐No
Have you received all three doses of the HPV vaccine?	☐Yes	☐No
Have you ever had herpes? If yes, where do you have outbreaks? _____ If yes, how often do you have outbreaks? _____	☐Yes	☐No
Have you ever had syphilis? If yes, how, when, and where were you treated? _____ _____	☐Yes	☐No
Have you ever had ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic inflammatory disease If yes, when, how, and where were you treated? _____	☐Yes	☐No
Have you ever used intrauterine device (IUD) for contraception? If yes, please indicate when? _____	☐Yes	☐No
Did you have any problem with the IUD? If yes, please describe:_____	☐Yes	☐No

PREGNANCY		
Have you ever had an infertility evaluation? If yes, when and what was done? _____	☐Yes	☐No

How many pregnancies? _____ Number of vaginal deliveries _____
Number of cesarean sections _____ Number of miscarriages _____ Number of abortions _____

#	Date	Sex	Weight at birth	Wks gest.	Type delivery	Details of delivery
1						
2						
3						
4						
5						

SOCIAL & DIETARY HISTORY		
Do you drink caffeine? If yes, cups per day_____	☐Yes	☐No
Do you exercise regularly?	☐Yes	☐No
Do you follow a particular diet? If yes, please describe:_____	☐Yes	☐No
Have you ever had an eating disorder?	☐Yes	☐No
Have you had all your vaccinations?	☐Yes	☐No
Do you do monthly self-breast exams?	☐Yes	☐No
Have you or your partner traveled outside the united states? If yes, please describe:_____	☐Yes	☐No
Do you currently or have you in the past year smoked, chewed, used any type nicotine delivery system (ENDS), or vaped? If yes, how many packs per day? ____ If former smoker/user, when did you quit? _____	☐Yes	☐No
Have you used any street drugs since your last menstrual period? (eg,cocaine,marijuana)? If yes, please indicate number of uses per week? _____ What type of drugs? _____	☐Yes	☐No
Do you drink alcoholic beverages now or did you before you became pregnant? If yes, please indicate number of drinks per week? _____ What type of drinks? _____	☐Yes	☐No
Have you been exposed to chemicals (e.g. Pesticides, lead, hazardous material/agents) or radiation (eg,X-rays) since you became pregnant? If yes, please describe: _____	☐Yes	☐No
Do you have any reason to believe you or your partner have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bi-sexual men or sex with someone who had used IV drugs?	☐Yes	☐No
Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____ _____		

PSYCHOSOCIAL SCREENING		
Do you have any problems (eg. job, transportation) that prevent you keeping your appointments?	☐Yes	☐No
Do you feel unsafe where you live?	☐Yes	☐No
Are you exposed to secondhand smoke	☐Yes	☐No
In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?	☐Yes	☐No
Has anyone forced you to perform any sexual act that you did not want to do?	☐Yes	☐No
On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High		
How many times have you moved in the past 12 months? _____		
If you could change the timing of this pregnancy, would you want it ☐ earlier ☐ later ☐ not at all/NA		

FAMILY HISTORY

Please check any diseases that a member of your family has been affected by, and list which members were affected and their age at diagnosis.

- ☐ Hypertension _____
- ☐ Lupus _____
- ☐ Arthritis _____
- ☐ Diabetes _____
- ☐ Intestinal Disease _____
- ☐ Cancer (type) _____
- ☐ Osteoporosis _____
- ☐ Heart Disease _____
- ☐ Alzheimer's _____
- ☐ Parkinson's Disease _____
- ☐ Birth Defects _____ ☐ Genetic Disorder _____

FAMILY HISTORY & GENETIC SCREENING

What is your ethnicity? _____

What is the ethnicity of the baby's father? _____

Have you or the baby's father have a child born with a birth defect? If yes, please describe:_____	☐Yes	☐No
Please describe any special needs that have occurred in children of your family or the baby's family (eg. Cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis): _____ _____ How is this child/person related to you? _____		
Do either you or the baby's father have a birth defect? If yes, please describe:_____	☐Yes	☐No
Have you had cystic fibrosis screening?	☐Yes	☐No
Have you had any other genetic carrier screening, such as an expanded carrier screening? Screening:_____ Date:_____ Result:_____	☐Yes	☐No
Do you want a test that will tell you about your risk to have a baby with down syndrome?	☐Yes	☐No
Is the father 45 years or older?	☐Yes	☐No
Do you or the baby's father have a history of pregnancy losses (miscarriages or stillbirth)? If yes, have either of you had genetic counseling? ☐Yes ☐No If yes, have either of you had chromosomal testing? ☐Yes ☐No Where and what were the results? _____		

Please list any other concerns you have about birth defects or inherited disorders:

_____

_____

GENETIC HISTORY (includes patient, baby's father, or anyone in either family with)		
Patient's Age >/= 35 @ Delivery	☐Yes	☐No
Thalassemia (Italian, Greek, Mediterranean, or Asian Background): MCV < 80	☐Yes	☐No
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)	☐Yes	☐No
Congenital Heart Defect	☐Yes	☐No
Down Syndrome	☐Yes	☐No
Tay-Sachs (eg Jewish, Cajun, French Canadian)	☐Yes	☐No
Canavan Disease	☐Yes	☐No
Sickle Cell Disease or Trait (African)	☐Yes	☐No
Hemophilia or Other Blood Disorders	☐Yes	☐No
Muscular Dystrophy	☐Yes	☐No
If yes, family affected and condition:_____		

GENETIC HISTORY		
Cystic Fibrosis	☐Yes	☐No
Huntington's Chorea	☐Yes	☐No
Intellectual Disability / Autism	☐Yes	☐No
If Yes, was the person tested for Fragile X?	☐Yes	☐No
Other Inherited Genetic or Chromosomal Disorder	☐Yes	☐No
Maternal Metabolic Disorder (eg Diabetes Type I, PKU)	☐Yes	☐No
Patient's or Baby's father had a child with birth defects not listed above	☐Yes	☐No
Recurrent Pregnancy Loss or Stillbirth	☐Yes	☐No
Medications (including supplements, vitamins, herbs, or over-the-counter drugs / Illicit or Recreational Drugs / Alcohol Since Last Menstrual Period	☐Yes	☐No
If yes, agents,strength/dose/frequency:_____		
Consanguinity	☐Yes	☐No
Any Other	☐Yes	☐No
If yes, family affected and condition:_____		

INFECTION & TRAVEL HISTORY		
Live with Someone with TB or Exposed to TB	☐Yes	☐No
Patient or Partner Has History of Genital Herpes	☐Yes	☐No
Rash or Viral Illness Since Last Menstrual Period	☐Yes	☐No
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis	☐Yes	☐No
Down Syndrome	☐Yes	☐No
Tay-Sachs (eg Jewish, Cajun, French Canadian)	☐Yes	☐No
Have Traveled Outside of the Continental US at Any Time During or 6 Months Before Pregnancy	☐Yes	☐No
If Yes to Any, Please Describe Further:		

Patient's Signature:_____ Date:_____