NORTHWEST PROFESSIONAL OBSTETRICS &GYNECOLOGY, LTD.

OBSTETRIC INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American
☐ More Than One Race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White
☐ Refused to Report/Unreported

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported

Language: ☐ English ☐ Spanish ☐ Other_____

Preferred Local Pharmacy: _____
(Address/City)

Do you use a mail order pharmacy? _____ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Preferred Mail Order Pharmacy: _____

Preferred Notification Method: ☐ Postal Mail ☐ Phone ☐ Web Message

Report any changes in your address, phone contact numbers, insurance, or emergency contact information to the front desk.

OB History:

How many times have you been pregnant? _____
How many pre-term deliveries? _____
How many full term deliveries? _____
How many stillbirths? _____
How many abortions, spontaneous? _____
How many abortions, induced? _____
How many ectopic pregnancies? _____
How many live births? _____

Date of Birth	Sex	Weight	Length of labor	Vaginal or Cesarean	Complications with pregnancy or delivery

Menstrual and Gynecological History:

Date of last period: _____
Date of previous period: _____
Was your last period normal: ☐ Yes ☐ No

Are your periods regular: ☐ Yes ☐ No
Do you have spotting between: ☐ Yes ☐ No
Age at first period: _____
How many days from the first day of my period to the first day of my next period: _____
How long do your periods last: _____
Is your flow: ☐ Light ☐ Moderate ☐ Heavy
Are your periods painful: ☐ Yes ☐ No
If your periods are painful, please describe the pain: ☐ Mild ☐ Moderate ☐ Severe
Do you have other symptoms with your periods: ☐ Yes ☐ No
If yes, please list: _____
Have you ever had an abnormal pap smear: ☐ Yes ☐ No
If yes, please when: _____
If yes, what was the diagnosis: _____
If yes, how were you treated: _____
Have you ever been sexually active: ☐ Yes ☐ No
At what age did you become sexually active: _____
How many sexual partners have you had: _____
Are you currently sexually active: ☐ Yes ☐ No
Are you using contraception: ☐ Yes ☐ No
Do you have a history of infertility: ☐ Yes ☐ No
Do you have bleeding after intercourse: ☐ Yes ☐ No
Do you have pain with intercourse: ☐ Yes ☐ No
Do you leak urine: ☐ Yes ☐ No
Do you have chronic pelvic pain: ☐ Yes ☐ No

Medical History:

Please indicate any maternal or family history that applies to you with a check mark placed on the lines below. (Page 1)

	Patient	Family		Patient	Family
Abuse	_____		DES Exposure	_____	
Alcohol Use	_____		Diabetes Mellitus	_____	_____
Anemia	_____		Down Syndrome	_____	_____
Autism	_____	_____	Drug Use	_____	
Autoimmune Disorder	_____		Endocrine Disorder	_____	_____
Asthma	_____		Exposure to Cat Feces	_____	_____
Bleeding/Clotting Disorder	_____	_____	Gastrointestinal Disorder	_____	
Blood Disorder	_____	_____	Gen. Anesthesia / Reaction	_____	_____
Caffeine Use	_____		Heart Disease	_____	_____
Canavan Disease	_____	_____	Hepatitis	_____	_____
Cancer	_____	_____	Herpes	_____	
Chromosomal Anomaly	_____	_____	HIV / AIDS	_____	_____
Congenital Anomaly	_____	_____	HPV	_____	_____
Congenital Heart Defect	_____	_____	Huntington's Disease	_____	_____
Cystic Fibrosis	_____	_____	Hypertension	_____	_____
Depression	_____		Infertility	_____	_____

(Medical History Continued, Page 2)

	Patient	Family		Patient	Family
Kidney Disease	_____	_____	Sickle Cell Disease	_____	_____
Liver Disease	_____		Sickle Cell Trait	_____	_____
Lung Disease	_____		Tay-Sachs Disease	_____	_____
Mental Retardation	_____	_____	Thalassemia	_____	_____
Migraine Headaches	_____	_____	Thyroid Disorder	_____	_____
Multiple Gestations	_____	_____	Tobacco Use	_____	
Muscular Dystrophy	_____	_____	Trauma	_____	
Musculoskeletal Condition	_____	_____	Transfusion	_____	
Neural Tube Defect	_____	_____	Tuberculosis	_____	_____
Neurologic Disorder	_____	_____	UTI / Recurrent	_____	
Pelvic Surgery	_____	_____	Uterine Anomaly	_____	
Phenylketonuria	_____	_____	Vascular Disease	_____	_____
Psychiatric Disorder	_____	_____	Violence	_____	_____
Rh Incompatibility	_____				
Seizure Disorder	_____	_____			
Sexual Transmitted Disease	_____	_____			

Past Surgical History:

List significant surgeries or injuries (continue on back if necessary):

Surgeries *Date(s) or Age*

_____

_____

_____

_____

Medication History:

List any medications, vitamins, minerals, and herbs that you are currently taking or check the box below:

☐ No Current Meds

_____

_____

_____

_____

_____

Allergy History:

List known allergies (including medication allergies) or check one of the boxes below:

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

_____

_____

_____

_____

Social History:

Please describe your current tobacco use?

☐Never Smoker ☐Former Smoker ☐Current every day smoker ☐Current some day smoker
☐Current status unknown ☐Unknown if ever smoked

Are you exposed to "second-hand" smoke**?** ☐Yes ☐No
If yes, please indicate by marking the appropriate boxes: ☐Minimal ☐Frequent ☐Daily
☐Family members smoke indoors ☐Family members smoke outdoors only

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

Do you drink beverages with caffeine? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐Yes ☐No
If yes, please indicate what type of drug and how often: _____

Do you drink beverages with alcohol? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day: _____

What religion do you follow: _____

What is your most recent primary occupation? _____

Travel History:

List places you have traveled in the past two years—particularly to areas outside of the continental United States:

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

Pregnancy Record Review of Systems:

- ❑ Fever
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Rash
- ❑ Blurred Vision
- ❑ Headache
- ❑ Bleeding Gums
- ❑ Difficulty Breathing
- ❑ Breast Mass
- ❑ Chest Pain
- ❑ Fainting/Blacking Out
- ❑ Elevated Blood Pressure
- ❑ Shortness of Breath
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Nausea
- ❑ Vomiting
- ❑ Contractions, Regular
- ❑ Frequency
- ❑ Decreased Fetal Movement
- ❑ Painful Urination
- ❑ Pelvic Pain
- ❑ Urinary Complaints
- ❑ Vaginal Bleeding
- ❑ Vaginal Discharge
- ❑ Vaginal Fluid
- ❑ Back Pain
- ❑ Leg Cramps
- ❑ Dizziness
- ❑ Depression