CARTERET OB-GYN ASSOCIATES
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OB Intake Packet

Please fill out this form to the best of your knowledge.

Please have this packet completed in order for your next visit to be done in a timely manner. **If you fail to complete and submit this packet 24 hours in advance of your appointment date, please arrive 30 minutes early or your appointment will be rescheduled.**

If you have any questions or concerns about this form, please list them at the bottom of this sheet and they will be addressed at your appointment.

Your appointment is scheduled for

____

Please remember:

- ❖ **Arrive 15 minutes prior to your appointment time.**
- ❖ **Bring your pregnancy statement if we do not already have it on file.**
- ❖ **No children under the age of 10 years will be allowed at this appointment.**
- ❖ **You are allowed to have 1 adult accompany you to this visit if you desire.**

Name/Patient #:________________
Appt Date:_____________________

MENSTRUAL HISTORY

Date of last menstrual period_______________/Unknown
Is date definite? NO/YES If no, give approximate month______________________
Was last menstrual period a normal amount/duration? NO/YES
Were you on any type of birth control at conception? NO/YES If yes, what kind?_______________

Choice of Pediatrician: Rule/Oceanside Peds/Cart. Child. Clinic/Base/Undecided/Other
____
Father of Baby?____

GENETIC SCREENING/TERATOLOGY

Will you (the patient) be age 35 years or older at estimated time of delivery? NO/YES
Have you had more than 2 miscarriages or pregnancy losses? NO/YES
If yes, explain____
Have you had a stillbirth/fetal demise? NO/YES
If yes, explain____

Please answer "Yes" if you (the patient), your partner, or anyone in either family has any of the following:

Neural tube defects (spina bifida, anencephaly)? NO/YES, explain who_____________________
Thalassemia? NO/YES, explain who_____________________
Down Syndrome? NO/YES, explain who_____________________
Tay Sachs? NO/YES, explain who_____________________
Canavan Disease? NO/YES, explain who_____________________
Sickle cell disease or trait? NO/YES, explain who_____________________
Familial dysautonomia? NO/YES, explain who_____________________
Hemophilia or other bleeding or clotting disorders? NO/YES, explain who_____________________
Muscular dystrophy? NO/YES, explain who_____________________
Cystic fibrosis? NO/YES, explain who_____________________
Huntington's chorea? NO/YES, explain who_____________________
Mental retardation? NO/YES, explain who_____________________
If yes, was this person tested for Fragile X? NO/YES
Autism? NO/YES, explain who_____________________
Other inherited genetic or chromosomal disorders? NO/YES, explain who_____________________

ANCESTRY

Is the patient's family of any of the following descents?
French Canadian? NO/YES
Ashkenazi Jewish? NO/YES
Cajun? NO/YES
Mediterranean? NO/YES
Greek? NO/YES
Italian? NO/YES
Asian? NO/YES

INFECTION HISTORY

Have you had a rash or viral illness since your last menstrual period? NO/YES
Do you live with someone with TB or exposed to TB? NO/YES
Do you or your partner have a history of genital herpes? NO/YES
Do you or your partner have a history of Hepatitis B or C? NO/YES
Do you have a history of any STDs (sexually transmitted diseases)? NO/YES
This includes: Gonorrhea, Chlamydia, HIV, Syphilis

ALLERGIES	MEDICATION	REACTION
Are you allergic to any medications?	____________________	____________
	____________________	____________
	____________________	____________
Do you have any common allergens?	____________________	____________
(ex. Dust, grass, mold, etc.)	____________________	____________
	____________________	____________

MEDICATIONS

Please list any medications you are currently taking:

________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________
________________Dose________ If stopped, when________________________

PAST GYNECOLOGICAL HISTORY

Do you have a history of any of the following:

Abnormal Pap smear	NO/YES	When?________________________
Have you had a LEEP or conization procedure	NO/YES	When?________________________
History of HPV	NO/YES	When?________________________
Infertility	NO/YES	Explain________________________
Uterine abnormality (such as Bicornuate, arcuate)	NO/YES	Explain________________________
DES (Diethylstilbuterol) Exposure	NO/YES	

PAST MATERNAL HISTORY

FIRST PREGNANCY:

DOB HOW FAR ALONG? LENGTH OF LABOR BIRTH WEIGHT M/F

____

DELIVERY TYPE ANESTHESIA DELIVERY DOCTOR PLACE OF DELIVERY PRETERM LABOR

____Yes/No_____

COMMENTS/COMPLICATIONS INDUCTION?

SECOND PREGNANCY:

DOB HOW FAR ALONG LENGTH OF LABOR BIRTH WEIGHT M/F

____

DELIVERY TYPE ANESTHESIA DELIVERY DOCTOR PLACE OF DELIVERY PRETERM LABOR

____Yes/No_____

COMMENTS/COMPLICATIONS INDUCTION?____

____

THIRD PREGNANCY:

DOB HOW FAR ALONG? LENGTH OF LABOR BIRTH WEIGHT M/F

____

DELIVERY TYPE ANESTHESIA DELIVERY DOCTOR PLACE OF DELIVERY PRETERM LABOR

____Yes/No_____

COMMENTS/COMPLICATIONS INDUCTION?____

____

FOURTH PREGNANCY:

DOB HOW FAR ALONG? LENGTH OF LABOR BIRTH WEIGHT M/F

____

DELIVERY TYPE ANESTHESIA DELIVERY DOCTOR PLACE OF DELIVERY PRETERM LABOR

____Yes/No_____

COMMENTS/COMPLICATIONS INDUCTION?____

____

FIFTH PREGNANCY:

DOB HOW FAR ALONG? LENGTH OF LABOR BIRTH WEIGHT M/F

____

DELIVERY TYPE ANESTHESIA DELIVERY DOCTOR PLACE OF DELIVERY PRETERM LABOR

____Yes/No_____

COMMENTS/COMPLICATIONS INDUCTION?____

____

FAMILY HISTORY

List any family history for a first degree relative(Father, Mother, Brother, Sister, Son, Daughter)

Diabetes:____
High Blood Pressure____
Heart Disease____
Breast Cancer____
Uterine Cancer____
Ovarian Cancer____
Colon Cancer____

SOCIAL HISTORY

Do you or have you ever:

Smoked? NO/YES — Amount per day **before** pregnancy________________________
Amount per day **during** pregnancy________________________
How many years?________________________
When did you quit?________________________

Drink alcohol? NO/YES — Amount per day **before** pregnancy________________________
Amount per day **during** pregnancy________________________
How many years?________________________

Use caffeine? NO/YES — If yes, how much per day________________________
Amount per day **before** pregnancy________________________
Amount per day **during** pregnancy________________________
How many years?________________________

Have you ever used drugs? NO/YES — Marijuana, Cocaine, Heroin, List others________________________
If so, when was the last time? ________________________
____

Do you feel safe at home? NO/YES — If no, please explain________________________
____
____

Do you have a history of sexual abuse/rape? NO/YES ________________________
____

Any history of Domestic Violence? ________________________

Will you accept blood transfusion in case of emergency? NO/YES ________________________
____

History of blood transfusion? NO/YES If yes, list date and reason of transfusion________________________
____
____

Will you breast feed or bottle feed? ________________________

PAST SURGICAL HISTORY

List any surgeries

________________________ When________________________

________________________ When________________________

________________________ When________________________

Do you have a history of anesthesia complications? NO/YES

If yes, explain________________________

Risk Factors for Lead Exposure in Pregnant and Lactating Women

Check all that apply:

- ☐ Recent immigration (within 1 year)
- ☐ Living near a point source of lead – lead mines, smelters, or battery recycling plants (even if the establishment is closed)
- ☐ Working with lead or living with someone who does – (eg. Lead production, battery manufacturing, paint manufacturing, ship building, ammunition production, or plastic manufacturing)
- ☐ Using lead-glazed ceramic pottery
- ☐ Eating non-food substances (pica)
- ☐ Using alternative or complementary substances, herbs, or therapies
- ☐ Using imported cosmetics or certain food products
- ☐ Engaging in certain high-risk hobbies or recreational activities or having family members who do – (eg. stained glass production or pottery making)
- ☐ Renovating or remodeling older homes without lead hazard controls in place
- ☐ Consumption of lead-contaminated drinking water
- ☐ Having a history of previous lead exposure or evidence of elevated body burden of lead
- ☐ Living with someone identified with an elevated lead level
- ☐ **None**

Print Name____DOB____________________

Signature__________________________________Date Completed____________________

Reviewed by _______________________________ Date_____________________________