north florida Women's Care
OBSTETRICS & GYNECOLOGY

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OB Initial Intake Information

Patient Info:

Name: Test Test Date of Birth:

Marital status: _____ Occupation: _____

Number of children at home: _____ Pre-pregnancy: Height: _____ Weight: _____

Father of Baby Information:

Name of Husband/Father of Baby: _____ Occupation: _____

Current Allergies:

Past Medical History:

Diabetes	High Blood Pressure	Cancer
Pelvic Problems	Back / Spine Problems	Heart Problems

Other (click the checkbox to type below)

Past Surgical History:

Past C-Sections Surgery on your uterus (womb) Other surgery (click the checkbox to type below)

Menstrual History:

When was your last period (date)? _____

At what age did you start your period? _____

How many days between the start of each cycle? _____

How many days does your period last? _____

Risk Factors:

Do you smoke? _____ If yes, how many packs per day? _____

If no, have you ever been a smoker? _____ How often for how many years? _____

Month/Year of quitting (if applicable): _____

Does anyone smoke around you? _____

Drug Use: _____

HIV high-risk behavior: _____

Caffeine Use: Number of caffeinated drinks per day: _____

Alcohol Use: _____ If yes, how many drinks per day? _____ per week? _____

Exercise: _____

Seatbelt Use: _____ If yes, what percentage? _____

Sun Exposure: _____

Family History (please list any medical conditions):

Father: _____

Mother: _____

Siblings: _____

Family History Risk Factors:

Family History of Heart Attack in females < 65 years old: _____

Family History of Heart Attack in males < 55 years old: _____

Past Pregnancy History:

Have you delivered a child before this pregnancy? _____

How many times have you been pregnant? _____ (Include all live births, miscarriages, and abortions)

How many babies have you had that were born at 37 weeks or greater? _____

How many babies have you had that were born prematurely – 36 weeks or less? _____

How many living children do you have? _____

How many sets of twins, triplets or other multiple births have you had? _____

How many previous C-Sections have you had? _____

Have you ever had a vaginal birth after a C-Section? _____

How many elective abortions have you had? _____ If any, when? _____

How many spontaneous miscarriages have you had? _____ If any, when? _____

How many ectopic pregnancies have you had? _____

Medications:

Please list ALL medications taken at, and since, conception including vitamins, herbs, and non-prescription medications.

Check here if you are not taking any medication(s)

Medication Name	Dosage	Frequency	Reason for medication

Current Pharmacy: _____ Pharmacy Location: _____

Pregnancy # 1 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 2 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 3 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 4 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 5 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 6 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 7 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Pregnancy # 8 (Check this box if this does not apply to you:)

Delivery Date: _____

How many weeks at delivery? _____

Preterm labor? (less than 37 weeks) _____

Type of Delivery: Vaginal: _____ C-Section: _____

How many hours in labor? _____

What type of anesthesia did you have? _____

Did you have any complications during the delivery? _____

What city and state did you deliver in? _____

What was the name of the hospital? _____

Name of doctor who delivered your baby: _____

Sex of baby: Male: _____ Female: _____

Weight of baby at birth: Pounds: _____ Ounces: _____

Name of baby: _____

Comments: _____

Genetic History:

Do you have any family history of:

Downs Syndrome? _____

Spina Bifida? _____

Cystic Fibrosis? _____

Trisomy 18? _____

Sickle Cell? _____

Other Genetic Disorders? Yes: _____ No: _____ If yes, please describe below:

_____

_____

Infection Risk History:

Are you at a high risk for Hepatitis B? _____

Have you been immunized against Hepatitis B? _____

Have you ever been exposed to Tuberculosis (TB)? _____

Do you have a history of Genital Herpes? _____

Have you ever had a sexual partner with history of Genital Herpes? _____

Do you have a history of an STD (Gonorrhea, Chlamydia, Syphilis, HPV)? _____

Have you had a rash, a virus, or an illness with a fever since your last period? _____

Do you have exposure to cat litter? _____

Have you ever had Chicken Pox? _____

Do you have a history of Parvovirus (Fifth Disease)? _____

Are you exposed to children with the work you do? _____

Environmental Exposures:

Have you had any Xray exposure since your last period? _____

Have you had any chemical or other exposure? _____

Have you had any medication, drug, or alcohol use since your last menstrual period? _____

Patient Signature:

Patient Name: **DOB:**