Lee Obstetrics and Gynecology

New Pregnancy Intake and Questionnaire

General Information:

☐ Check here if you are already an established patient at Lee Obstetrics and Gynecology

(If so, please list any changes in your personal information below)

Name: _____

Address: _____

_____

Emergency Contact Person: _____

Relation: _____

Contact Number: _____

Phone Numbers: Home: _____

Mobile: _____

Work: _____

Place of Employment: _____

Type of Work: _____

Is there any heavy lifting or strenuous activity associated with your position? ☐ Yes ☐ No

_____

_____

When was the first day of your last period? _____/_____/_____ (date)

Medical History:

Have you ever had Chicken Pox (or had the vaccine)? ☐ Yes ☐ No

Do you or have you been diagnosed with any of the following medical problems?

☐ Hypertension	☐ Diabetes	☐ Asthma	☐ Chest Pain
☐ Stroke	☐ Blood Clots	☐ Kidney Disorders	☐ Lupus
☐ Anemia	☐ Sickle Cell	☐ Heart Condition	☐ Chronic Pain
☐ Back pain	☐ Edema		

If you checked any above or have any other chronic (longstanding) medical problems, please describe in detail on the next page:

Medical Problem	Date diagnosed?	Managing Physician?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(List any additional medical problems on the back of this sheet)

Medications:

Do you currently take any prescription or non-prescription medications (including herbal supplements)?
☐ Yes ☐ No (if "yes" describe below)

Medication	Dose	Prescribing Physician?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken any prescription or non-prescription medication (including herbal supplements) for more than 2 weeks? ☐ Yes ☐ No (if "yes" describe below)

Medication	Dose	Prescribing Physician?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Are you allergic to Latex? ☐ Yes ☐ No

Medication	Year Diagnosed	Reaction to Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History:

Have you ever had any type of surgery? ☐ Yes ☐ No (if "yes" describe below)

Type of Surgery	Date Performed	Surgeon (add location if not local MD)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Obstetrical History:

Please list all pregnancies below; please include any miscarriages and/or abortions

Date	Vaginal/C-section	Male/Female	Weight	Delivering Physician and Location
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Please list any additional deliveries on back of page) ☐ Check here if more are listed on the back

Did you use fertility medication during this pregnancy? ☐ Yes ☐ No

Were you under the care of a Reproductive Specialist? ☐ Yes ☐ No

Pregnancy Complications or Significant Events:

During pregnancy: (Please check if occurred during any of your pregnancies)

- ☐ High Blood Pressure
- ☐ Break your water before 37 weeks
- ☐ Regular Contraction before 37 weeks
- ☐ Need for Cerclage Placement
- ☐ Referral to High Risk
- ☐ Genetic or Structural Issues with the Baby
- ☐ Excessive vomiting requiring hospitalization
- ☐ Fetal Death
- ☐ Delivery Before 37 weeks
- ☐ Infection or Severe Illness
- ☐ Bleeding after 20 weeks
- ☐ Diabetes (diet or medication controlled)
- ☐ Growth Problems with the Baby
- ☐ Need for more than 2 Ultrasounds
- ☐ Problems with the Placenta
- ☐ Admission to the Hospital during Pregnancy

Please describe in more detail on the next page if you checked any of the above and describe any additional pregnancy issues during your pregnancies that you may have had.

Additional Information:

Please list below any information that you think we need to know that would help us take care of you during your pregnancy.

Gynecologic History:

Date of Last Pap Smear: _____/_____/_____ (date)

Do you have a history of any abnormal pap smears? ☐ Yes ☐ No

Have you ever had any of the following procedures performed on your cervix?

☐ Colposcopy _____/_____/_____(date)

☐ LEEP _____/_____/_____(date)

☐ Cold Knife Conization _____/_____/_____(date)

Do you have a history of any sexually transmitted diseases?

☐ Genital Herpes ☐ Syphilis

☐ Chlamydia ☐ HIV

☐ Gonorrhea

Social History:

☐ Single ☐ Separated

☐ Married ☐ Divorced

☐ Engaged

Do you currently use tobacco in any form? ☐ Yes ☐ No

If yes, how much per day? _____

Have you recently quit using tobacco? ☐ Yes ☐ No

If yes, how long has it been since you quit? _____

Do you currently drink alcohol in any form? ☐ Yes ☐ No

If yes, how much per day? _____

Do you currently use any drugs in any form? ☐ Yes ☐ No

If yes, how much per day? _____

Family History:

Does your family or your husband/partner's family have a history of any of the following or other genetic abnormalities or birth defects?

☐ Mental Retardation	☐ Cystic Fibrosis
☐ Down's Syndrome	☐ Canavan Disease
☐ Duchenne Muscular Dystrophy	☐ Hemophilia
☐ Cardiac (Heart) Defects	☐ Neural Tube Defects
☐ Neurofibromatosis	☐ Phenylketonuria
☐ Polycystic Kidney Disease	☐ Tay-Sachs Disease
☐ Turner Syndrome	☐ Spinal Muscular Dystrophy

Please describe more in detail below if you checked any if the above, and describe additional genetic abnormalities or birth defects in your family:

_____
_____
_____
_____