Lee Obstetrics and Gynecology

New Pregnancy Intake Questionnaire

General Information:

☐ Check here if already an established patient at Lee Obstetrics and Gynecology
(If so, please list any change in your personal information below)

Name: _____

Address: _____

_____

Emergency Contact Person: _____

Relation: _____

Contact Number: _____

Phone Numbers: Home: _____

Mobile: _____

Work: _____

Place of Employment: _____

Type of Work: _____

Any heavy lifting or strenuous activity associated with your position? ☐ Yes ☐ No (if "yes" describe below)

_____

_____

Medical History:

Have you ever had Chicken Pox (or had the vaccine)? ☐ Yes ☐ No
Do you have 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 next page:

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

(List any additional on back of this sheet)

Medications:

Do you currently take any prescription or non-prescription medication (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 or abortions

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

(please list any additional deliveries on back) Circle if more listed on 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 contractions before 37 weeks
___ Need for cerclage placement
___ Referral to high risk OB/GYN (UAB)
___ Genetic or structural issues with the baby
___ Excessive vomiting requiring hospitalization
___ Fetal Death
___ Delivery before 37 weeks
___ 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 hospital during pregnancy
___ Infections or severe illnesses

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

Pregnancy complications:

_____
_____
_____
_____
_____
_____
_____

During Delivery: (Please check if occurred during the delivery of your baby)

___ Forceps or vacuum delivery

___ Anesthesia complications

___ Problems with delivering baby's shoulders

___ Need for blood transfusion

___ Need for antibiotics

___ Placental abruption

___ Large vaginal tear (3rd or 4th degree)

___ Fetal macrosomia (baby larger than 9 lbs)

___ Large amount of bleeding during delivery

___ Abnormal or worrisome fetal heart tracing

___ Seizure

___ Need for Magnesium infusion

Please describe in more detail below if you checked any of the above, and describe any additional issues during your delivery that you may have had:

_____
_____
_____
_____
_____
_____
_____

After Delivery: (Please check if occurred after the delivery of your baby)

___ Large amount of bleeding

___ Depression

___ Infection

___ Need for blood transfusion

___ Blood Clots

___ High blood pressure

___ Seizure

___ Heart issues

___ Need for readmission to hospital

Please describe in more detail below if you checked any of the above, and describe any additional issues during your delivery that you may have had:

_____
_____
_____
_____
_____
_____
_____

Gynecologic History

When was your 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 you cervix?
___ Colposcopy _____ (date)
___ LEEP _____ (date)
___ Cold Knife Conization _____ (date)

Do you have a history of any sexually transmitted diseases?

___ Herpes Virus (1 or 2) ___ Chlamydia ___ Gonorrhea ___ Syphilis
___ HIV

Social History

___ Single ___ Married ___ Divorced ___ Separated ___ 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 yours or your husband's (partner's) family have a history of any of the following or other genetic abnormalities or birth defects?

___ Mental Retardation
___ Down's Syndrome
___ Duchenne Muscular Dystrophy
___ Cardiac (Heart) Defects
___ Neurofibromatosis
___ Polycystic Kidney Disease
___ Turner Syndrome
___ Cystic Fibrosis
___ Canavan Disease
___ Haemophilia
___ Neural Tube Defects
___ Phenyketonuria
___ Tay-Sachs Disease

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

_____
_____
_____

Additional Information:

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____