

# Lee Obstetrics and Gynecology

## New Pregnancy Intake Questionnaire

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### 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:

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

- |  |   |
|--|---|
| <input type="checkbox"/> Forceps or vacuum delivery                | <input type="checkbox"/> Large vaginal tear (3 <sup>rd</sup> or 4 <sup>th</sup> degree) |
| <input type="checkbox"/> Anesthesia complications                  | <input type="checkbox"/> Fetal macrosomia (baby larger than 9 lbs)                      |
| <input type="checkbox"/> Problems with delivering baby's shoulders | <input type="checkbox"/> Large amount of bleeding during delivery                       |
| <input type="checkbox"/> Need for blood transfusion                | <input type="checkbox"/> Abnormal or worrisome fetal heart tracing                      |
| <input type="checkbox"/> Need for antibiotics                      | <input type="checkbox"/> Seizure  |
| <input type="checkbox"/> Placental abruption                       | <input type="checkbox"/> 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:

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

- |   |   |
|---|---|
| <input type="checkbox"/> Large amount of bleeding   | <input type="checkbox"/> High blood pressure              |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Seizure                          |
| <input type="checkbox"/> Infection                  | <input type="checkbox"/> Heart issues                     |
| <input type="checkbox"/> Need for blood transfusion | <input type="checkbox"/> Need for readmission to hospital |
| <input type="checkbox"/> Blood Clots                |   |

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:

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## 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

\_\_\_ Cystic Fibrosis

\_\_\_ Down's Syndrome

\_\_\_ Canavan Disease

\_\_\_ Duchenne Muscular Dystrophy

\_\_\_ Haemophilia

\_\_\_ Cardiac (Heart) Defects

\_\_\_ Neural Tube Defects

\_\_\_ Neurofibromatosis

\_\_\_ Phenylketonuria

\_\_\_ Polycystic Kidney Disease

\_\_\_ Tay-Sachs Disease

\_\_\_ Turner Syndrome

\_\_\_ Spinal Muscular Atrophy

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:

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**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:

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