New Life
OB/GYN ASSOCIATES

OB Intake Form

Patient Name _____ Age _____ DOB _____

Husband/Father of Baby _____ Age _____ Phone _____

Pharmacy of Choice & Address _____ Phone _____

Date of last PAP smear? _____ Was it normal? Yes ☐ No ☐

Please check past treatments required ☐LEEP ☐Conization ☐Cryotherapy

Were you using birth control pills (Y / N) or an IUD (Y / N) when you became pregnant?

Menstrual History

Date of last Menstrual Period _____ ☐Definite ☐Approx (Month Known) ☐Unknown

Menses Monthly ☐Yes ☐No Frequency: Every _____ days

☐Home pregnancy test positive _____/_____/_____ Age of first menstrual cycle: _____

Past Pregnancies

# of Pregnancies _____ # of Deliveies _____ # of Elective Abortions _____ # of Miscarriages _____

Date/Hospital	# Weeks Pregnant	Infant Weight	Vaginal/C-Section	Hrs in Labor	Epidural Y / N	Any problems?

Please check if you had any of these conditions during your past pregnancies:

☐Increased blood pressure ☐"Toxemia" ☐Preterm Labor ☐Abruption ☐Gestational Diabetes

Allergies

Drug	Reaction	Drug	Reaction

Check if you are allergic to ☐Shellfish ☐Iodine ☐Penicillin ☐Latex

Past Medical Illnesses (have you been treated for any of these?)

Yes	No	Illness	Yes	No	Illness
		Irregular Heart Beat			Kidney Stones
		Congestive Heart Failure			Chicken Pox (Have you had it)
		Heart Murmur			Sickle Cell Disease/Trait
		Rheumatic Fever			Arthritis
		Any other Heart Condition			Skin Disease, Type:
		Blood Clot in Leg, Lung or Varicose Veins			Stroke
		High Cholesterol			Epilepsy / Seizures
		High Blood Pressure			Migraine Headache
		Heart Murmur			Diabetes / High Blood Sugar
		Asthma			Thyroid Problems – too high or too low
		Emphysema / Chronic Bronchitis			Anemia / Low Blood
		Tuberculosis			Bleeding Problems Type:
		Gallstones			Blood Transfusion
		Liver Disease, Including Hepatitis			Cancer, Type:
		Ulcers in Bowels/Stomach			Anxiety or Depression
		Kidney Disease, Type:			Psychological Problems
		Genital Herpes, Genital Warts,			Sexually Transmitted Disease -If YES please circle: HIV, Chlamydia, Gonorrhea, Syphilis
		Infertility Treatments			
		Other:			Other:

Medications

What medications have you taken during this pregnancy (Including birth control pills and drugs you buy without a prescription)?

Drug	Dosage	Drug	Dosage	Drug	Dosage

Past Medical Surgeries (have you been treated for any of these?)

Yes	No	Surgery	Date	Yes	No	Surgery	Date
		Appendectomy				Joint Replacement	
		Joint Scope Surgery				Back Disc Surgery	
		Biopsy of:				Abdominal Surgery	
		Open Heart Surgery				Tonsils Removed	
		Neck Artery Surgery				Wisdom Teeth Extraction	
		Eye Surgery R L				D&C	
		Gallbladder				Vaginal Surgery	
		Broken Bone Repair				Other:	

Other Specialty Doctors You See

Specialty	Name	City	Phone

Your Family History and Father of the Baby History

(Disease affecting your parents, grandparents, brothers and sisters only. Please note the person)

Yes	No	Illness	Who	Yes	No	Illness	Date
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes / High Blood Sugar	
		Asthma				Thyroid Problems	
		TB Family member or household contact				Cancer, Type:	
		Liver Disease				Infant surgery	
		Kidney Disease				Anxiety or Depression	
		Birth defects				Infant Death, Stillborn, Birth Defect (please circle)	
		Stroke				Other:	
		Epilepsy / Seizures					

Comments: _____

_____

Social History

Smoking: Have you ever smoked: ☐Yes ☐No How many years did you smoke? _____

How many packs per day do you smoke now: ___ Do you plan on stopping for this pregnancy? ☐Yes ☐No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Illicit/Recreational Drugs:

☐Yes ☐No In the last year, have you ever drunk alcohol or used drugs more than you meant to?

What drugs have you used in the past? _____

What drugs do you currently use? _____

How often do you use caffeine a day? _____ Do you have any indoor cats?_____

Please Check one

Do you plan to: ☐Breast Feed ☐Bottle Feed ☐Undecided

Do you want an Epidural? ☐Yes ☐No ☐Undecided

Please tell me how you feel about this pregnancy. (happy, disappointed, confused, traumatized, etc)

Do you need to talk to someone about other pregnancy options or counseling for this pregnancy? _____

_____

Infection History

Yes	No	Illness	Yes	No	Illness
		Live with someone with TB or exposed to TB			Hepatitis B or C (please circle)
		Patient or partner has history of genital herpes			History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis (circle all that apply)
		Rash or viral illness since last menstrual period (please circle)			Other (see comments)

Comments: _____

Genetic Screening/Teratology Counseling
(Includes Patient, Baby's Father, or anyone in either family)

Yes	No		Yes	No	
		Patients age 36 years or older as of estimated date of Delivery			Huntington's Chorea
		Thalassemia, (Italian, Greek, Mediterranean, or Asian background) MCV les than 80			Mental Retardation/Autism If YES, was person tested for Fragile X?
		Neural Tube Defect(Meningomyelocele, Spina Bifida, or Anencephaly)			Other inherited Genetic or Chromosomal disorder
		Congenital Heart Defect			Maternal Metabolic Disorder (Ex: Type 1 diabetes, PKU)
		Down Syndrome			Patient or Baby's father had a child with birth defects not listed above
		Tay-Sachs(Ashkenazi Jewish, Cajun, French Canadian)			Recurrent Pregnancy loss or a stillborn
		Canavan Disease(Ashkenazi Jewish)			Medications(including supplements, vitamins, herbs, or OTC drugs) Illicit/Recreational drugs/Alcohol since last menstrual period If YES List Drugs and Strength/Dosage _____
		Family Dysautonomia(Ashkenazi Jewish)			
		Sickle Cell Disease or Trait(African)			
		Hemophilia or other blood disorders			
		Muscular Dystrophy			Any Other: _____
		Cystic Fibrosis			

Accurate information is critical to your care. We will make every effort to safeguard your information. Thank you for helping us to serve you.

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Ultrasound Examination in Pregnancy

What is an ultrasound examination?
An ultrasound exam is a procedure that uses sound waves to create pictures of the uterus, placenta, and fetus. There is no exposure to radiation and no known risk. Early pregnancy scans are frequently done using a vaginal probe covered with a clean, disposable sheath. There is usually no significant discomfort, no known risk of infection or harm to the pregnancy using this technique. Scanning in later pregnancy is usually done with a larger tranducer, placed on your abdomen.

Ultrasound scanning may be used:

- To make sure the baby is developing in the uterus and not inside a fallopian tube or elsewhere (ectopic pregnancy); this type of exam is almost always done in the first 12 weeks of pregnancy (first trimester).
- To determine how far along you are in your pregnancy (which will help to determine your most likely due date).
- To check that the baby is alive and growing normally (the finding of a baby that is either smaller or larger for this state of your pregnancy may suggest a problem).
- To check the weight of the baby.
- To check the position of both the baby and the placenta (an unusual position of either could affect the method of your delivery).
- To check the amount of fluid around the baby (in some instances, either too much or too little fluid can be a reason for further investigation).
- To see how many babies are in the uterus (twins or more).
- To look for fetal movement and fetal breathing (both of which are reassuring during the latter part of your pregnancy).
- To look for any structural abnormalities that may be detected by ultrasound.

Looking for Structural Abnormality:
The prevalence of major structural abnormalities is low, approximately 1-2% of all births. It is possible that at this point in your pregnancy, an increase in that risk may have been detected and your doctor may have recommended further investigation. In most instances, this investigation begins with an ultrasound.

Unfortunately, neither ultrasound scanning nor any other testing can detect all birth defects. Up to one third of all major defects will not be detected by normal procedures.

Maternal Obesity:
Increasing maternal size and obesity can reduce the detection of abnormalities in routine ultrasound examinations by as much as 60%. In scans directed specifically at suspected abnormalities, that reduction is predicted as greater than 20%.

How Do I Decide Whether to Proceed with the Ultrasound Examination?:
Most ultrasound examinations are performed for reassurance, to obtain better dates, and for the satisfaction of the patient and family. It is again important to understand that only a small percentage of pregnancies are associated with a major fetal defect. By this time, you should understand whether there is an increased risk in your particular case. Additionally, the identification of a major problem may not lead to a specific treatment, as the majority of non-lethal abnormalities are not suitable for treatment prior to delivery.

However, identification of an abnormality may facilitate many treatment options after the delivery, as well as inform you and your family about expectations.
You must ultimately make decisions based on your own value system. There is not always a single right choice.

Please initial the following if you are in agreement:

___ I understand the advantages and disadvantages of the proposed testing, along with any significant risks of the intervention.

___ I understand that there is a significant possibility of not visualizing an abnormality that might be present.

___ I understand there may be alternatives to these plans.

___ I further understand that there may be risks associated with declining the ultrasound.

___ I am free to pursue a second opinion.

Please initial one of the following:

___ I understand the reason for an ultrasound, I also understand the limitations of ultrasound examination and wish to continue with the procedure. I have had all my questions answered.

___ I understand the reasons for an ultrasound. I also understand the limitations of ultrasound examination and DO NOT wish to continue with the procedure. I have had all my questions answered.

Patient Signature _____ Date _____

Witness _____ Date _____