MOONTOWER MIDWIFERY & WELLNESS

NEW CLIENT INTAKE FORM

DEMOGRAPHICS

CLIENT NAME DOB AGE

PREFERRED NAME PRONOUNS

PRIMARY LANGUAGE RACE / ETHNICITY

PHONE EMAIL

ADDRESS CITY / ST / ZIP

EMERGENCY CONTACT PHONE

EMPLOYER OCCUPATION

MARITAL STATUS : SINGLE / MARRIED / COMMITTED RELATIONSHIP / NON-MONOGAMOUS

PARTNER NAME PHONE PRONOUNS

PRIMARY CARE PROVIDER

WHO CAN WE THANK FOR REFERRING YOU?

PAST MEDICAL HISTORY

DATE OF LAST ANNUAL EXAM DATE/TYPE OF LAST LAB WORK DATE OF LAST PAP SMEAR

HAVE YOU HAD AN ABNORMAL PAP SMEAR? YES / NO LIST DATES & TREATMENT

DATES / RESULTS OF LAST MAMMOGRAM

DATE / RESULTS OF LAST COLONOSCOPY/FLEXSIGMOIDOSCOPY

DATE / RESULTS OF LAST BONE DENSITY SCAN

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES / NO LIST DATE / REASON

WOULD YOU ACCEPT BLOOD OR BLOOD PRODUCTS IN CASE OF AN EMERGENCY? YES / NO IF NOT, PLEASE EXPLAIN

DID YOUR MOTHER RECEIVE A DRUG CALLED DES WHEN SHE WAS PREGNANT WITH YOU? YES / NO

DO YOU HAVE AN ADVANCED DIRECTIVE?

REPRODUCTIVE HISTORY

AGE AT FIRST PERIOD EVERY HOW MANY DAYS? LASTING HOW MANY DAYS?

FLOW: LIGHT / MEDIUM / HEAVY / CLOTS SYMPTOMS: CRAMPS / PELVIC PAIN / HEADACHES / MOOD CHANGES

DATE YOUR LAST PERIOD STARTED HOW CERTAIN ARE YOU? VERY / SOMEWHAT / NOT AT ALL

CURRENT BIRTH CONTROL METHOD (I.E. CONDOMS, BIRTH CONTROL PILLS/RING/PATCH, IUD, MENOPAUSE, HYSTERECTOMY)

DO YOU DESIRE A CHANGE?

ARE YOU MENOPAUSAL? NA / YES / NO AGE AT MENOPAUSE

ARE YOU ON HORMONES? YES / NO TYPE?

TOTAL # OF PREGNANCIES # OF TERM DELIVERIES (AFTER 36 WEEKS) # OF PRETERM DELIVERIES (BEFORE 36 WEEKS)

HOW MANY CESAREAN SECTIONS HOW MANY LIVING CHILDREN

ABORTIONS (PLEASE LIST APPROXIMATE YEAR)

MISCARRIAGES (PLEASE LIST APPROXIMATE YEAR)

ECTOPICS (LIST DATES, WEEKS OF PREGNANCY, TREATMENT)

PREGNANCY OR DELIVERY COMPLICATIONS

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PERSONAL AND FAMILY HISTORY

PLACE AND "X" IN THE WHITE BOXES THAT APPLY

	YOU	MOTHER	FATHER	MATERNAL GRANDMA	MATERNAL GRANDPA	PATERNAL GRANDMA	PATERNAL GRANDPA	BROTHERS / SISTERS	CHILDREN	OTHER FAMILY MEMBERS
ANEMIA										
ASHKENAZI JEWISH DESCENT (EASTERN EUROPEAN OR RUSSIAN)										
ARTHRITIS										
ASTHMA										
BIRTH DEFECTS (I.E. CLEFT PALATE, SPINA BIFIDA...)										
CLOTTING DISORDER OR DEEP VEIN THROMBOSIS										
BLOOD DISORDERS (I.E. ITP, SICKLE CELL)										
BREAST DISORDERS										
CANCER, BREAST										
CANCER, COLON										
CANCER, OVARIAN										
CANCER, UTERINE / ENDOMETRIAL										
COLON POLYPS										
DIABETES										
ENDOMETRIOSIS										
EPILEPSY										
GALLBLADDER DISEASE										
GENETIC DISORDERS (I.E. MENTAL RETARDATION, CYSTIC FIBROSIS...)										
GLAUCOMA										
HEART DISEASE OR MITRAL VALVE PROLAPSE										
HIGH BLOOD PRESSURE										
HIGH CHOLESTEROL										
KIDNEY DISORDER / DISEASE										
MENTAL ILLNESS, TYPE?										
MENSTRUAL IRREGULARITIES										
OSTEOPOROSIS										
PELVIC INFLAMMATORY DISORDER										
STROKE										
THYROID DISORDER										
UTERINE ANOMALIES										
STILL LIVING?	X									
DECEASED AT AGE?	—									
OTHER DISEASES / ILLNESSES										

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SURGICAL HISTORY

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE UNDERGONE (D&C, HYSTERECTOMY, CESAREAN SECTION)

YEAR OF SURGERY	TYPE / REASON	MD	HOSPITAL

MEDICATIONS

LIST MEDICATIONS (INCLUDING OVER-THE-COUNTER AND SUPPLEMENTS), DOSES, THE REASON YOU ARE TAKING, AND WHO PRESCRIBED IT:

ALLERGIES

LIST DRUG ALLERGIES (AND THE REACTION YOU HAD):

SOCIAL HISTORY

DO YOU FEEL SAFE IN YOUR CURRENT RELATIONSHIP? YES / NO IF NOT, PLEASE EXPLAIN

HAVE YOU EVER BEEN PHYSICALLY ABUSED IN A RELATIONSHIP? YES / NO IF SO, PLEASE EXPLAIN

HAVE YOU EVER HAD AN UNWANTED SEXUAL ENCOUNTER? YES / NO IF SO, PLEASE LET US KNOW WHEN THIS OCCURRED

DO YOU DRINK ALCOHOL? YES / NO HOW MANY DRINKS PER DAY OR WEEK?

DO YOU CURRENTLY USE ANY ILLICIT DRUGS? YES / NO

IF YES, WHAT TYPE? HOW OFTEN?

DO YOU USE TOBACCO? CURRENT / FORMER / NEVER IF CURRENT, HOW MANY CIGARETTES / DAY?

WHEN DID YOU START / STOP SMOKING?

DO YOU EXERCISE? YES / NO TYPE FREQUENCY

HAVE YOU EVER BEEN SEXUALLY ACTIVE? YES / NO ARE YOU CURRENTLY SEXUALLY ACTIVE YES / NO

SEXUAL PREFERENCE

ARE YOU INTERESTED IN STI TESTING? YES / NO

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (STD)? YES / NO

- ☐ HEPATITIS (TYPE?)
- ☐ SYPHILIS (WHEN? TREATED?)
- ☐ CHLAMYDIA (WHEN? TREATED?)
- ☐ GONORRHEA (WHEN? TREATED?)
- ☐ GENITAL HERPES (TAKING MEDS?)
- ☐ HPV (HUMAN PAPILLOMA VIRUS)
- ☐ GENITAL WARTS)

HAVE YOU EVER HAD MRSA (METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS)? YES / NO

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THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY (ACOG) RECOMMENDS

HIV SCREENING FOR ALL WOMEN AGES 19-64
HIV SCREENING SEXUALLY ACTIVE TEENAGERS UNDER THE AGE OF 19
HIV SCREENING FOR WOMEN OLDER THAN 64 WHO HAVE HAD MULTIPLE PARTNERS IN RECENT YEARS
ANNUAL CHLAMYDIA SCREENING OF ALL SEXUALLY ACTIVE WOMEN AGE 25 AND YOUNGER
HPV (HUMAN PAPILLOMA VIRUS) SCREENING FOR WOMEN OVER THE AGE OF 30

I WOULD LIKE TO BE SCREENED FOR SEXUALLY TRANSMITTED DISEASES TODAY YES / NO NOTE: WE CAN'T GUARANTEE INSURANCE COVERAGE FOR ANY TESTS

HAVE YOU EVER RECEIVED OR STARTED THE IMMUNIZATION SERIES FOR HPV (HUMAN PAPILLOMA VIRUS) CALLED GARDASIL? YES / NO

REVIEW OF SYMPTOMS

CONSTITUTIONAL

FREQUENT FATIGUE	CURRENT	PAST	N / A
EXCESS WEIGHT GAIN	CURRENT	PAST	N / A
EXCESS WEIGHT LOSS	CURRENT	PAST	N / A

EYES, EARS, NOSE, MOUTH

FREQUENT OR SEVERE HEADACHES	CURRENT	PAST	N / A
FREQUENT LIGHTHEADEDNESS	CURRENT	PAST	N / A

BREASTS

LUMPS	CURRENT	PAST	N / A
PAIN	CURRENT	PAST	N / A
SWELLING	CURRENT	PAST	N / A
NIPPLE DISCHARGE	CURRENT	PAST	N / A

CARDIOVASCULAR

CHEST PAIN	CURRENT	PAST	N / A
FAINTING	CURRENT	PAST	N / A
SWOLLEN / PAINFUL VARICOSE VEINS	CURRENT	PAST	N / A
CALF PAIN	CURRENT	PAST	N / A

RESPIRATORY

FREQUENT SHORTNESS OF BREATH	CURRENT	PAST	N / A
FREQUENT HOARSENESS	CURRENT	PAST	N / A

GASTROINTESTINAL

NAUSEA / VOMITING	CURRENT	PAST	N / A
FREQUENT DIARRHEA	CURRENT	PAST	N / A
FREQUENT CONSTIPATION	CURRENT	PAST	N / A
FREQUENT HEARTBURN / REFLUX	CURRENT	PAST	N / A
ABDOMINAL PAIN	CURRENT	PAST	N / A
BLOOD IN STOOL	CURRENT	PAST	N / A
HEMORRHOIDS	CURRENT	PAST	N / A

MUSCULOSKELETAL

JOINT PAIN	CURRENT	PAST	N / A
JOINT SWELLING	CURRENT	PAST	N / A
RECENT BACK PAIN	CURRENT	PAST	N / A

HEMATOLOGIC / LYMPHATIC

EASY BLEEDING	CURRENT	PAST	N / A
EASY BRUISING	CURRENT	PAST	N / A

GENITOURINARY

URGENCY	CURRENT	PAST	N / A
FREQUENCY	CURRENT	PAST	N / A
PAIN WITH URINATION	CURRENT	PAST	N / A
BLOOD IN URINE	CURRENT	PAST	N / A
FREQUENT URINE LEAKAGE	CURRENT	PAST	N / A
PAIN WITH INTERCOURSE	CURRENT	PAST	N / A
GENITAL SORES	CURRENT	PAST	N / A
IRREGULAR PERIODS	CURRENT	PAST	N / A
PAINFUL PERIODS	CURRENT	PAST	N / A
HEAVY PERIODS	CURRENT	PAST	N / A
NO PERIODS	CURRENT	PAST	N / A
POSSIBLE PREGNANCY	CURRENT	PAST	N / A
ABNORMAL VAGINAL DISCHARGE	CURRENT	PAST	N / A
SIGNIFICANT PMS	CURRENT	PAST	N / A

INTEGUMENT (SKIN)

NEW SKIN LESIONS	CURRENT	PAST	N / A
CHANGES TO MOLES / SKIN LESIONS	CURRENT	PAST	N / A

ENDOCRINE

EXCESS BODILY HAIR GROWTH	CURRENT	PAST	N / A
EXCESS HAIR LOSS	CURRENT	PAST	N / A
COLD INTOLERANCE	CURRENT	PAST	N / A
HEAT INTOLERANCE	CURRENT	PAST	N / A
ACNE	CURRENT	PAST	N / A
THYROID ABNORMALITIES / TREATMENT	CURRENT	PAST	N / A

PSYCHIATRIC

FREQUENT ANXIETY	CURRENT	PAST	N / A
FREQUENT DEPRESSION	CURRENT	PAST	N / A
SUICIDAL THOUGHTS	CURRENT	PAST	N / A
PSYCHIATRIC TREATMENT	CURRENT	PAST	N / A

LIST ANY OTHER SYMPTOMS BOTHERING YOU TODAY

HEIGHT WEIGHT

PRINTED PATIENT NAME

PATIENT SIGNATURE

DATE COMPLETED