MOONTOWER MIDWIFERY & WELLNESS

NEW OB PATIENT INTAKE

NAME:	DOB:
PRIMARY LANGUAGE:	RACE/ETHNICITY:
PHONE:	EMAIL:
ADDRESS:	
PHARMACY:	PHARMACY PHONE:
PARTNER NAME:	PARTNER PHONE #:
HEIGHT:	PRE PREGNANCY WEIGHT:
MEDICATIONS:	ALLERGIES:
RECENT VACCINES:	
PRIMARY CARE PROVIDER:	
EMERGENCY CONTACT:	PHONE:
MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED COMMITTED RELATIONSHIP NON-MONOGAMOUS	

GYNECOLOGICAL HISOTRY:

1ST DAY OF YOUR LAST PERIOD:	DATE OF + UPT:	WERE YOU ON BIRTH CONTROL? **YES NO**
LAST PAP SMEAR DATE: ABNORMAL PAP:	HPV STATUS: ***NEG POS UNSURE***	HPV VAX COMPLETE: ***YES NO UNSURE***
HISTORY OF CERVICAL DYSPLASIA? ***YES NO***	HISTORY OF VULVAR DYSPLASIA: ***YES NO***	ARE YOU CURRENTLY SEXUALLY ACTIVE? ***YES NO***
AGE AT 1ST INTERCOURSE:	AGE WHEN YOU STARTED YOUR PERIOD:	DO YOU HAVE SEXUAL TRAUMA:
DO YOU HAVE A HISTORY OF THE FOLLOWING:	❑ ENDOMETRIOSIS ❑ FIBROIDS ❑ INFERTILITY ❑ RECURRENT OVARIAN CYSTS	❑ PCOS ❑ PAINFUL PERIODS ❑ OTHER:

HOW LONG ARE YOUR CYCLES (ex 28-30d):	DAYS IRREGULAR: _______________
HOW MANY DAYS DO YOU BLEED:	DAYS IRREGULAR: ______________

NAME: **DOB:**

OBSTETRICAL HISTORY

Total # of Pregnancies (including this one)	
Full term:	
Premature <37wks:	
Abortions induced:	
Abortions spontaneous:	
Ectopic:	
Multiple births:	
Living children:	

PAST PREGNANCY INFORMATION

#1 DATE:__________	☐ MALE ☐ FEMALE NAME:	**#2 DATE:**__________	☐ MALE ☐ FEMALE NAME:
GESTATIONAL AGE:	WEEKS: ______ DAYS ______	GESTATIONAL AGE:	WEEKS: ______ DAYS ______
BABY WEIGHT:	LBS_________ OZ _____	BABY WEIGHT:	LBS_________ OZ _____
MODE OF DELIVERY:	☐ VAGINAL ☐ C/SEC ☐ VBAC ☐ VAVD	MODE OF DELIVERY:	☐ VAGINAL ☐ C/SEC ☐ VBAC ☐ VAVD
WERE YOU INDUCED:	☐ NO ☐ YES	WERE YOU INDUCED:	☐ NO ☐ YES
LENGTH OF LABOR:		LENGTH OF LABOR:	
WAS ANESTHESIA USED:	☐ NONE ☐ EPIDURAL ☐ SPINAL ☐ GENERAL	WAS ANESTHESIA USED:	☐ NONE ☐ EPIDURAL ☐ SPINAL ☐ GENERAL
PRE-TERM LABOR?	☐ NO ☐ YES	PRE-TERM LABOR?	☐ NO ☐ YES
WHERE DID YOU DELIVER?	☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL	WHERE DID YOU DELIVER?	☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL
#3 DATE:__________	☐ MALE ☐ FEMALE NAME:	**#4 DATE:**__________	☐ MALE ☐ FEMALE NAME:
GESTATIONAL AGE:	WEEKS: ______ DAYS ______	GESTATIONAL AGE:	WEEKS: ______ DAYS ______
BABY WEIGHT:	LBS_________ OZ _____	BABY WEIGHT:	LBS_________ OZ _____
MODE OF DELIVERY:	☐ VAGINAL ☐ C/SEC ☐ VBAC ☐ VAVD	MODE OF DELIVERY:	☐ VAGINAL ☐ C/SEC ☐ VBAC ☐ VAVD
WERE YOU INDUCED:	☐ NO ☐ YES	WERE YOU INDUCED:	☐ NO ☐ YES
LENGTH OF LABOR:		LENGTH OF LABOR:	
WAS ANESTHESIA USED:	☐ NONE ☐ EPIDURAL ☐ SPINAL ☐ GENERAL	WAS ANESTHESIA USED:	☐ NONE ☐ EPIDURAL ☐ SPINAL ☐ GENERAL
PRE-TERM LABOR?	☐ NO ☐ YES	PRE-TERM LABOR?	☐ NO ☐ YES
WHERE DID YOU DELIVER?	☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL	WHERE DID YOU DELIVER?	☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL

NAME: **DOB:**

SOCIAL HISTORY

HISOTRY OF DOMESTIC VIOLENCE?	❑ YES ❑ NO COMMENTS:
ARE YOU CURRENTLY IN SCHOOL?	❑ YES FOR:____________________ ❑ NO
ARE YOU CURRENTLY EMPLOYED?	❑ YES ❑ NO OCCUPATION:________________________
DO YOU HAVE AN ADVANCE DIRECTIVE?	❑ YES ❑ NO
IS BLOOD TRANSFUSION ACCEPTABLE?	❑ YES ❑ NO
WHAT TYPE OF DIET ARE YOU FOLLOWING?	❑ REGULAR ❑ VEGETARIAN ❑ VEGAN ❑ DIABETIC ❑ SPECIFIC:____________________
WHAT IS YOUR EXERCISE LEVEL?	❑ NONE ❑ OCCASIONAL ❑ MODERATE ❑ HEAVY
HOW MANY DAYS A WEEK DO YOU EXERCISE?	❑ LESS THAN 1 TIME PER WEEK ❑ 1-2 TIMES A WEEK ❑ 3-4 TIMES A WEEK ❑ 5-7 TIMES A WEEK
DO YOU SMOKE TOBACCO?	❑ NEVER SMOKER ❑ FORMER SMOKER ❑ OCCASIONAL SMOKER ❑ CURRENT EVERYDAY SMOKER ❑ CURRENT SOME DAY SMOKER
DO YOU DRINK ALCOHOL?	❑ NONE ❑ OCCASIONAL ❑ MODERATE ❑ HEAVY
DO YOU DO ANY ILLICIT OR RECREATIONAL DRUGS?	❑ YES ❑ NO
WHAT IS YOUR LEVEL OF CAFFEINE CONSUMPTION?	❑ NONE ❑ OCCASIONAL ❑ MODERATE ❑ HEAVY
SEXUAL ORIENTATION?	
ARE YOU INTERESTED IN STD TESTING?	❑ YES ❑ NO
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (STD)? IF SO, WRITE DATE AND IF TREATED	❑ NONE ❑ HERPES ❑ HPV ❑ GENITAL WARTS ❑ HEPATITIS ❑ SYPHILLIS (WHEN?) ❑ CHLAMYDIA ❑ GONORRHEA ❑ HIV ❑ MRSA

SURGICAL HISTORY

PLEASE LIST ANY SURGERIESE OR HOSPITALIZATION YOU HAVE UNDERGONE (D&C, HYSTERECTOMY, C/SECTION, AUGMENTATIONS)

YEAR OF SURGERY	TYPE/REASON	MD	HOSPITAL

Name: **DOB:**

PATIENT PERSONAL AND FAMILY HISTORY

PLACE AN "X" IN THE WHITE BOXES THAT APPLY

	YOU	MOTHER	FATHER	MATERNAL GRANDMA	MATERNAL GRANDPA	PATERNAL GRANDMA	PATERNAL GRANDPA	SIBLINGS	CHILDREN
ANEMIA									
ASHKENAZI JEWISH									
ARTHRITIS									
ASTHMA									
BIRTH DEFECT (CLEFT PALATE, SPINA BIFIDA)									
BLOOD DISORDER									
BREAST DISORDER									
CANCER, BREAST									
CANCER, COLON									
CANCER, OVARIAN									
CANCER, UTERINE/ENDOMETRIAL									
COLON POLYPS									
DIABETES									
ENDOMETRIOSIS									
EPILEPSY									
GALLBLADDER DISEASE									
GENETIC DISORDER (MENTAL RETARDATION, CYSTIC FIBROSIS)									
GLAUCOMA									
HEART DISEASE OR MITAL VALVE PROLAPS									
HIGH BLOOD PRESSURE									
HIGH CHOLESTEROL									
KIDNEY DISORDER/ DISEASE									
MENTALL ILLNESS TYPE?									
MENSTRUAL IRREGULARITIES									
OSTEOPOROSIS									
PELVIC INFLAMMATORY DISEASE									
STROKE									
THYROID DISORDER									
UTERINE ANOMALIES									
STILL LIVING?	X								
DECEASED AT AGE?	-								
OTHER									

NAME: **DOB:**

GENETIC SCREENING AND INFECTION HISTORY

	Y/N	NOTES
Patient's Age Will Be 35 Years Or Older At Estimated Date of Delivery	❑ Yes ❑ No	
Thalassemia (Italian, Greek, Mediterranean, Or Asian Background): MCV < 80	❑ Yes ❑ No	
Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly)	❑ Yes ❑ No	
Congenital Heart Defect	❑ Yes ❑ No	
Down Syndrome	❑ Yes ❑ No	
Tay-Sachs (eg, Jewish, Cajun, French-Canadian)	❑ Yes ❑ No	
Canavan Disease	❑ Yes ❑ No	
Sickle Cell Disease Or Trait (African)	❑ Yes ❑ No	
Hemophilia Or Other Blood Disorders	❑ Yes ❑ No	
Muscular Dystrophy	❑ Yes ❑ No	
Cystic Fibrosis	❑ Yes ❑ No	
Huntington's Chorea	❑ Yes ❑ No	
Mental Retardation or Autism	❑ Yes ❑ No	
If Yes, Was Person Tested For Fragile X?	❑ Yes ❑ No	
Other Inherited Genetic Or Chromosomal Disorder	❑ Yes ❑ No	
Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)	❑ Yes ❑ No	
Patient Or Baby's Father Had A Child With Birth Defects Not Listed Above	❑ Yes ❑ No	
Recurrent Pregnancy Loss, Or A Stillbirth	❑ Yes ❑ No	
Medications (including Supplements, Vitamins, Herbs, OTC Drugs), Illicit/Recreational Drugs, Alcohol	❑ Yes ❑ No	
If Yes, Agent(s) And Strength/Dosage	❑ Yes ❑ No	
Any Other Genetic History	❑ Yes ❑ No	
Live With Someone With TB Or Exposed To TB	❑ Yes ❑ No	
Patient Or Partner Has History Of Genital Herpes	❑ Yes ❑ No	
Rash Or Viral Illness Since Last Menstrual Period	❑ Yes ❑ No	
History Of STD, Gonorrhea, Chlamydia, HPV, Syphilis	❑ Yes ❑ No	
History of HIV	❑ Yes ❑ No	
History of Hepatitis	❑ Yes ❑ No	
Other Infection History	❑ Yes ❑ No	
Prior GBS-infected child	❑ Yes ❑ No	