Print Form Email Form

Hutzel Women's
HEALTH SPECIALISTS

Today's Date: _____

OB (PREGNANCY) PATIENT INTAKE HISTORY

Patient's Name: _____

Date of Birth: _____ Age: _____ Spouse/Partner's Name: _____

How many times have you been pregnant (including this pregnancy)? _____

How many living children? _____ How many deceased children? _____

Spontaneous miscarriages? _____ How many terminations? _____

How many stillbirths? _____ How many cesarean sections? _____

Please list your children below:

Name	DOB	Health Problems

Please list any children of the father of this pregnancy not listed above:

Name	DOB	Health Problems

Do You:		
Have diabetes?	☐ Yes	☐ No
Have HIV?	☐ Yes	☐ No
Have seizures or epilepsy?	☐ Yes	☐ No
Have kidney disease?	☐ Yes	☐ No
Does your partner have a history of cancer treatment?	☐ Yes	☐ No
Have rheumatoid arthritis or systemic lupus Erythematosus (SLE)?	☐ Yes	☐ No
Have a history of being on a special diet as a baby or small child?	☐ Yes	☐ No
Have a household cat or clean a litter box?	☐ Yes	☐ No
Eat raw or very rare meat?	☐ Yes	☐ No
Smoke? How many packs of cigarettes per day? _____	☐ Yes	☐ No
Have you had any surgeries? _____	☐ Yes	☐ No
Have you ever been told you have cervical incompetence?	☐ Yes	☐ No
Is there anything else you think your doctor should know?	☐ Yes	☐ No

If yes, please explain: _____

_____

Family History:		
Are you or the father of the baby of African American descent?	☐ Yes	☐ No
Have you had Sickle Cell testing? If yes, when: _____		
Are you or the father of the baby of Jewish descent?	☐ Yes	☐ No
Have you had Tay Sachs testing? If yes, when: _____		
Are you or the father of the baby of Mediterranean descent?	☐ Yes	☐ No
Have you had Thasselemia testing? If yes, when: _____		
Neural tube defect (spina bifida, anencephaly)?	☐ Yes	☐ No
If yes, who? _____		
Hemophilia?	☐ Yes	☐ No
If yes, who? _____		
Muscular dystrophy?	☐ Yes	☐ No
If yes, who? _____		
Cystic Fibrosis?	☐ Yes	☐ No
If yes, who? _____		
Down Syndrome (Mongolism)	☐ Yes	☐ No
If yes, who? _____		
Other chromosomal abnormalitites?	☐ Yes	☐ No
If yes, what and who? _____		
Have you ever had problems with any previous pregnancy?	☐ Yes	☐ No
If yes, please explain: _____		
_____		

During the current pregnancy:		
Vaginal bleeding?	☐ Yes	☐ No
Infection or flu (more than just a cold)?	☐ Yes	☐ No
Fever above 101 degrees?	☐ Yes	☐ No
Exposure to X-rays (without shielding)?	☐ Yes	☐ No
Taken any medications (prescribed or over the counter)?	☐ Yes	☐ No
_____		
Used any street drugs?	☐ Yes	☐ No
_____		
If you consumed alcohol during this pregnancy, please answer the following questions:		
Have you felt you ought to cut down on your drinking?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No