New Pregnancy Intake Form

Texas Health Care Obstetrics and Gynecology

Name:_____ Date:_____
Birthdate:_____Age:_____ Race:_____
Marital Status: S M W D Sep Preferred Language:_____
Occupation:_____ Education:_____
Partner/Father of Baby:_____ Phone:_____
Preferred Pharmacy:_____ Pharmacy phone:_____

Menstrual History:

1st day of last period:_____ Is this date certain?_____ Was this a normal period?_____
Are periods typically monthly?_____Average interval of periods (cycle length) _____days
Age your periods began?_____
Were you using birth control when you became pregnant? _____ If so, what type?_____
Was this planned pregnancy? Yes No
Date of positive pregnancy test:_____ blood?_____ urine?_____

Pregnancy History:

Total # of pregnancies _____

Full Term Births		Premature Births		Multiple Births		Number of living Children	
Spontaneous Miscarriages		Induced Abortions		Ectopic Pregnancies		Notes:	

Pregnancy Details:

Date	How many weeks	Length of labor	Baby's weight	Sex of baby	Vaginal? Csection? VBAC?	Anesthesia	Preterm labor?	Place of delivery	Comments/complications

Medical/Family History

	Personal History	Family History
Diabetes		
High blood pressure		
Heart disease		
Autoimmune disease		
Kidney disease		
Neurologic disorder/Epilepsy		
Psychiatric		
Post Partum Depression		
Depression/Anxiety		
Hepatitis/Liver Disease		
Varicosities/Phlebitis/Blood Clots		
Thyroid dysfunction		
Trauma/Violence		
History of blood transfusion		
Asthma/other pulmonary problems		
Seasonal Allergies		
Infertility		
DES exposure		

Do you know your blood type?_____ Have you ever received "Rhogam"?_____

Allergies:

Please list any medicine or food allergies with their reaction(s):

_____

_____

Are you allergic or sensitive to LATEX?_____

Gynecology History:

When was your Last pap_____

Do you have any History of abnormal pap?_____ Any treatment for abnormal pap?_____

Surgical History:

Procedure	Date	Complications/comments

Any other hospitalizations?_____

Genetic History:

	Personal History	Immediate Family History or Father's Family History
Are you over age 35		
Thalassemia		
Neural Tube Defect		
Congenital heart defect		
Downs Syndrome (or other chromosome problems)		
Tay-Sachs		
Canavan disease		
Sickle Cell disease or trait		
Hemophilia or other bleeding disorders		
Muscular Dystrophy		
Cystic Fibrosis (carrier or disease)		
Huntington's Chorea		
Mental Retardation/Autism • If yes: Has fragile X testing been done? y/n		
Other inherited/genetic disorder		
Metabolic disorders: Diabetes Type I, PKU, etc		
Other history of birth/congenital defects		
Recurrent pregnancy loss or stillbirth at any age		

Infection Screening

Have you travelled outside of the United States in the past 6 months?_____
Have you travelled to Southern Texas or Florida?_____
Exposure to tuberculosis:_____
Have you had a rash or viral illness since your last period? _____
Is there a history of Herpes (you or partner)? _____
Do either you or your partner have a history of Gonorrhea, Chlamydia, Syphilis, HIV?_____

Exposure History

Please list any medications (including vitamins, supplements, over the counter medications taken since your last period: _____

_____

Do you use now, or have you used in the past?

	Amount/Day Pre-pregnancy	Amount/Day During Pregnancy	# years use
Tobacco (including vapes)			
Alcohol			
Other drugs: _____			

Are you safe at home?_____ Do you need any help?_____

Do you have any other concerns to address with your doctor and her team?_____

_____