A Bella Baby OBGYN

OBSTETRIC INTAKE AND HISTORY FORM

Today's Date:_____

Name: _____ **Date of Birth:** _____

Language: ☐ English ☐ Spanish ☐ Other_____

Preferred Local Pharmacy:_____
(Address/City)

Preferred Notification Method: ☐ Mail ☐ Phone ☐ Email ☐ Text

Report any changes in your address, phone contact numbers, insurance, or emergency contact information to the front desk.

OB History:

How many times have you been pregnant? _____
How many pre-term deliveries? _____
How many full term deliveries? _____
How many stillbirths? _____
How many spontaneous miscarriages? _____
How many ectopic pregnancies? _____
How many terminations? _____
How many live births? _____

Date of Birth	Sex	Weight	Length of labor	Vaginal or Cesarean	Complications with pregnancy or delivery

Menstrual and Gynecological History:

First date of last period: _____
Date of previous period: _____
Was your last period normal? ☐ Yes ☐ No
Are your periods regular? ☐ Yes ☐ No

Do you have spotting between periods? ☐ Yes ☐ No
Age at first period: _____
How many days from the first day of your period to the first day of your next period: _____
How long do your periods last? _____
Is your flow: ☐ Light ☐ Moderate ☐ Heavy
Are your periods painful? ☐ Yes ☐ No
If your periods are painful, please describe the pain: ☐ Mild ☐ Moderate ☐ Severe
Do you have other symptoms with your periods? ☐ Yes ☐ No
If yes, please list: _____

When was your last pap smear?
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
If yes, please when: _____
If yes, what was the diagnosis:
If yes, how were you treated: _____

Are you using contraception? ☐ Yes ☐ No
Do you have a history of infertility? ☐ Yes ☐ No
Do you have bleeding after intercourse? ☐ Yes ☐ No
Do you have pain with intercourse? ☐ Yes ☐ No
Do you leak urine? ☐ Yes ☐ No
Do you have chronic pelvic pain? ☐ Yes ☐ No

Medical History:

Please indicate any maternal or family history that applies to you with a check mark placed on the lines below.

	You	Family		You	Family
Abuse	☐	☐	Diabetes Mellitus	☐	☐
Alcohol Use	☐	☐	Drug use	☐	☐
Anemia	☐	☐	Endocrine Disorder	☐	☐
Autism	☐	☐	Exposure to Cat feces	☐	☐
Autoimmune Disorder	☐	☐	Gastrointestinal Disorder	☐	☐
Asthma	☐	☐	General Anesthesia/Reaction	☐	☐
Bleeding/Clotting Disorder	☐	☐	Heart Disease	☐	☐
Blood Disorder	☐	☐	Hepatitis	☐	☐
Caffeine Use	☐	☐	Herpes	☐	☐
Cancer	☐	☐	HIV	☐	☐
Chromosomal Anomaly	☐	☐	HPV	☐	☐
Congenital Anomaly	☐	☐	Hypertension	☐	☐
Depression	☐	☐	Infertility	☐	☐
DES Exposure	☐	☐	Kidney Disease	☐	☐

(Medical History Continued,)

	You	Family		You	Family
Liver Disease	☐	☐	Thyroid Disorder	☐	☐
Lung Disease	☐	☐	Tobacco Use	☐	☐
Multiple Gestation	☐	☐	Trauma	☐	☐
Neurologic Disorder	☐	☐	UTI/Recurrent UTI	☐	☐
Pelvic Surgery	☐	☐	Uterine Anomaly	☐	☐
Phenylketonuria	☐	☐	Vascular Disease	☐	☐
Psychiatric Disorder	☐	☐	Violence	☐	☐
RH Incompatibility	☐	☐			
Seizure disorder	☐	☐			
Sexual Transmitted Disease	☐	☐			

Past Surgical History: List significant surgeries or injuries

Medication History: List any medications, vitamins, minerals, and herbs that you are currently taking

☐ No Current Meds

Allergy History:

List known allergies (including medication allergies) or check one of the boxes below

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

Social History:

Please describe your current tobacco use?
☐Never Smoker ☐Former Smoker ☐Current every day smoker ☐Current some day smoker
☐Current status unknown ☐Unknown if ever smoked

Are you exposed to "second-hand" smoke**?** ☐Yes ☐No
If yes, please indicate by marking the appropriate boxes: ☐Minimal ☐Frequent ☐Daily
☐Family members smoke indoors ☐Family members smoke outdoors only

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

Do you drink beverages with caffeine? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐Yes ☐No
If yes, please indicate what type of drug and how often: _____

Do you drink beverages with alcohol? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day: _____

What religion do you follow? _____

What is your most recent primary occupation? _____

Husband/Partner Name_____ Phone Number_____

Travel History:
List places you have traveled in the past two years—particularly to areas outside of the continental United States:

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

Review of Systems:

- ❑ Fever
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Rash
- ❑ Blurred Vision
- ❑ Headache
- ❑ Bleeding Gums
- ❑ Difficulty Breathing
- ❑ Breast Mass
- ❑ Chest Pain
- ❑ Fainting/Blacking Out
- ❑ Elevated Blood Pressure
- ❑ Shortness of Breath
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Nausea
- ❑ Vomiting
- ❑ Contractions, Regular
- ❑ Frequency
- ❑ Decreased Fetal Movement
- ❑ Painful Urination
- ❑ Pelvic Pain
- ❑ Urinary Complaints
- ❑ Vaginal Bleeding
- ❑ Vaginal Discharge
- ❑ Vaginal Fluid
- ❑ Back Pain
- ❑ Leg Cramps
- ❑ Dizziness
- ❑ Depression

For the purpose of Genetic Screening, please mark the following ethnic group

	You	Spouse
White (not of Hispanic origin)	☐	☐
Black (not of Hispanic origin	☐	☐
Mellado (not of Hispanic origin)	☐	☐
Asian or pacific islander (not of Hispanic origin)	☐	☐
Hispanic	☐	☐
Other	☐	☐

Genetic Screen

Mark Y is anyone in your family or your spouse's family have had the following. Mark N if it is not applicable

Screening	Y or N	Screening	Y or N
Will you be less than 35 yrs at time of delivery?	☐☐	Autism	☐☐
Neural Tube defect Spina bifida/anencephaly	☐☐	If yes to autism, was person tested for Fragile X?	☐☐
Trisomy 21	☐☐	Mental Retardation	☐☐
Congenital Heart Defect	☐☐	If yes to mental retardation, was the person tested for Fragile X?	☐☐
Tay-Sachs Disease	☐☐	Sickle cell disease or trait	☐☐
Canavan Syndrome	☐☐	Recurrent pregnancy loss/ stillbirth	☐☐
Hemophilia or Hematological Disease	☐☐	Other Inherited Genetic/chromosomal disorder	☐☐
Huntington's Disease	☐☐	Other Birth Defect	☐☐
Huntington's Chorea	☐☐		

Submitting Your Questionnaire to A Bella Baby OBGYN

Once you have completed the form fields above there are two ways to send your completed information:

1) **Email.** Save this PDF to your computer with a unique name. i.e. “Jane Doe’s Questionnaire.pdf”. Then email this completed form as an email attachment to **abellababyobgyn@outlook.com**

2) Fax: 630-810-1077