Capital Women's Care Div 65 | Midwives of Loudoun

19450 Deerfield Avenue, Suite 460, Leesburg, VA
www.cwcashburn.com
Instagram : midwives_of_loudoun

OB INTAKE FORM

Name:________________________ Date:______________
Preferred Name:_______________ DOB:______________

First day of Last Menstrual Period (LMP):		How confident are you of this date of last period?	High	Low
Are your periods typically regular and predictable?	Yes No	Have you had a rash or viral illness since LMP?	Yes	No
When was your last Pap test?		Was it normal?	Yes	No
Have you ever had an abnormal Pap test?	Yes No	Have you ever had a cervical procedure?	No Colpo	LEEP Cone Biopsy
Have you ever had an STI?	Yes No	If yes, When? ________	What was the result? Gonorrheaa HIV	Chlamydia Syphilis Herpes

PREGNANCY SYMPTOMS: Are you having any of these symptoms currently?

Symptoms	Yes	No	Symptoms	Yes	No	Symptoms	Yes	No	Symptoms	Yes	No
Cramping			Headache			Vaginal Discharge			Constipation		
Fever			Nausea			Vaginal Bleeding			Heartburn		
Leg Swelling			Vomiting			Spotting			Anxiousness		
Breast Tenderness			Difficulty Urinating			Pelvic Pain			Fatigue		
Other (please specify):											

PREGNANCY HISTORY: Have you given birth before? (Leave blank if answer is no)

DOB	Provider & Location	Baby Name	Weeks	Baby weight	Sex M/F	Type of delivery (Vaginal, Caesarean Vacuum, Forceps)	Living Y/N	Complications (GDM, high BP, IUGR, hemorrhage, shoulder dystocia, etc.)

MISCARRIAGE/ABORTION HISTORY: Have you ever had a miscarriage or terminated a pregnancy? (Leave blank if answer is no)

Date	Weeks	Type (Spontaneous, Termination, or Ectopic)	Management (None, Medication, D&C)		Date	Weeks	Type (Spontaneous, Termination, or Ectopic)	Management (None, Medication, D&C)

GENETIC HISTORY: Please indicate whether YOUR FAMILY OR YOUR PARTNER'S FAMILY has any history of the following:

Diagnosis	Yes (Relationship)	No	Diagnosis	Yes (Relationship)	No
Thalassemia			Hemophilia or other blood disorder		
Neural tube defect			Muscular dystrophy		
Congenital heart defect			Cystic fibrosis		
Down syndrome			Huntington's chorea		
Tay Sachs			Intellectual disability / developmental delay		
Canavan disease			Other inherited genetic or chromosomal disorder		
Familial dysautonomia			Metabolic disorder (Type 1 diabetes, PKU)		
Sickle cell trait or disease			Recurrent pregnancy loss or stillbirth		
Other (please specify):					

ALLERGIES: Do you have any medication allergies? (Leave blank if answer is no)

Allergy:	Reaction:		Allergy:	Reaction:
Allergy:	Reaction:		Allergy:	Reaction:

MEDICAL HISTORY: Have YOU ever been told that YOU had any of these conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Type 1 Diabetes			Varicosities / Phlebitis			Uterine Anomaly / DES		
Type 2 Diabetes			Thyroid Disease			Infertility		
Hypertension			Trauma / Violence			IUI or IVF Treatment		
Heart Disease or Defect			History of Blood Transfusions			Stroke / Blood Clot		
Autoimmune Disorder			D (Rh) sensitized			Bleeding Disorders		
Kidney disease (UTI)			Pulmonary (TB, Asthma)			PCOS or Insulin Resistance		
Neurologic (Epilepsy / Seizures)			Seasonal Allergies			Migraines		
Anxiety			Drug/Latex Allergies			Fibroids		
Depression			Breast Problems			Cancer		
Postpartum Depression			GYN Surgery			Crohn's, Colitis, or IBS		
Other Psychiatric Diagnosis			Operations / Hospitalizations			Live with someone with TB or exposed to TB?		
Liver disease (Hepatitis B or C)			Anesthetic Complications			History of MDRO infection (ESBL, MIRSA, VRE)		
Other (please specify):						Would you consent to a blood tranfusion if needed?		

SURGICAL HISTORY: What surgeries have you had in the past?

Year:	Surgery Type:	Year:	Surgery Type:
Year:	Surgery Type:	Year:	Surgery Type:

SOCIAL HISTORY: Please answer the following questions about your daily habits.

Tobacco	Never Current Past	Type:	Frequency:	Amount:
Alcohol	Never Current Past	Type:	Frequency:	Amount:
Caffeine	Never Current Past	Type:	Frequency:	Amount:
Illicit Drug	Never Current Past	Type:	Frequency:	Amount:

What is your Activity Level? Moderate Sedentary Vigorous Walking	How would you describe your diet?
What is your occupation?	Do you feel safe at home?

FAMILY HISTORY: Do you have any family history of medical illnesses? (Please specify if "Maternal" or "Paternal)

Disease	Yes	No	Relationship
Type 1 Diabetes			Relationship to you:
Type 2 Diabetes			Relationship to you:
Hypertension			Relationship to you:
Blood clots in legs or lungs			Relationship to you:
Stroke			Relationship to you:
Thyroid Disease			Relationship to you:
Cancer			Relationship to you: Type: Age at Diagnosis:
Other (Please Specify):			

MEDICATION/SUPPLEMENTS: List all that you take daily and as needed

Prenatal Vitamin Folic Acid DHA Iron Vitamin D			
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Are there any medications (including supplements, vitamins, herbs or OTC drugs) that you have recently stopped taking?			