# Intake Form

Patient Med Rec. #: _______________
Office Use Only

Date: _________________ Initial: _____________

**Visit Type:**

New GYN: ☐ Transfer OB: ☐ Pre-Conception Consult: ☐
New OB: ☐ Fetal Reduction: ☐ Consultation: ☐

Referring Physician: ________________________ Phone: ______________________ Fax#: ________________________

**Principal Complaint:**

|  |
|---|
|  |

**Record Request**: (All Consultations and OB transfers; Check All that apply)

|  | **Requested** | **Received** |
|---|---|---|
| Prenatal Records: | ☐ | ☐ |
| Prenatal Labs: | ☐ | ☐ |

Last Menstrual Period: _________________

Expected Delivery Date: _________________

**G**ravida (Number of pregnancies): ___
**P**reterm Births (Prior to 37 weeks gestation): ___
**A**bortions: ___
**T**erm Births: ___
**L**iving Children: ___

IVF/Transfer Date: ____________________

Patient Name: _____________________________ D.O.B: ______________________________ Age: ________

Address: ___________________________________________________________________________________________

Marital Status: Married Single Widowed Divorced Separated Spouse's Name: ____________________

Insurance: ______________________ Policy #: ______________________ Group#:_______________

P.O. Box: ______________________ City: __________________ ST: ______ Zip: ___________

Guarantor: Self Spouse D.O.B: ______________ S.S. #: ______________________

Home Phone #: _______________________ Cell Phone #: ________________________

Employer: ___________________________ Work #:______________________________

Emergency Contact: ________________________ Phone #: _____________________________

Mother's First Name: _______________________ Father's First Name: ___________________

Physician: ____________________ Appt Date: ____________ Time: _____:_____AM/PM
Ultrasound Appt Date: _______________________ Time: _____:_____AM/PM
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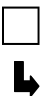
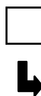
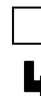
☐ 
**IRVING PAVILION**
*161 Ft. Washington Avenue*
*New York, NY 10032*
*165th Street / 4th Floor*
Phone: 212-305-7334
Fax: 212-305-1848

☐ 
**COLUMBIA EASTSIDE**
*16 East 60th Street*
*New York, NY 10022*
*4th Floor / Suite 480*
Phone: 212-326-8951
Fax: 212-326-5610

☐ 
**CENTER FOR PRENATAL PEDIATRICS**
*3959 Broadway*
*New York, NY 10032*
*CHONY Central 12th Floor*
Phone: 212-305-3151
Fax: 212-342-2802

Name: ______________________________________
MRN: ________________ DOB: ________________

**Obstetrical History Questionnaire***

| Total # of Pregnancies | # of Term Births (>37 wks) | # of Premature Births (<37 wks) | # of Abortions | # of Miscarriages | # of Living Children |
|---|---|---|---|---|---|
| | | | | | |

**Past Pregnancies (# should equal total # of pregnancies listed above)***

| # | Month/ Yr | Birth/ Miscarriage/ Termination/ Ectopic | Wks Pregna nt | Birth Wt | Sex | Delivery Type | Place of Delivery | Comments/Complications |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |

**Medical History**

| Condition | Y/N | Condition | Y/N | Condition | Y/N |
|---|---|---|---|---|---|
| Asthma | | Diabetes | | Seizures/Convulsions/Epilepsy | |
| Pneumonia | | High Blood Pressure | | Gastrointestinal Problems | |
| Chronic Lung Disease | | Stroke | | Glaucoma | |
| Tuberculosis | | Rheumatic Fever | | Arthritis/Joint pain | |
| Kidney Disease | | Cancer | | Fracture | |
| Sexually Transmitted Infections | | Ulcers | | Hepatitis/Liver Disease | |
| Heart Trouble/Murmur | | Depression/Anxiety | | Thyroid Disease | |
| | | Anemia/Blood Transfusions | | | |

**Family History (List any relatives that have the following conditions)***

| Condition | Relative(s) | Condition | Relative(s) |
|---|---|---|---|
| Diabetes | | Cancer | |
| High Blood Pressure | | Psychiatric | |
| Heart Disease | | Other | |



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Name: ______________________________________
MRN: ________________ DOB: ________________

**Genetic Screening (Mark both Mother's and Baby's Father's ethnic backgrounds)**

| Ethnic Origin | X | Ethnic Origin | X |
|---|---|---|---|
| Ashkenazi Jewish | | Asian | |
| Sephardic Jewish | | Italian | |
| French Canadian | | Greek | |
| Caucasian | | Middle Eastern | |
| African American, African or Black | | Hispanic | |
| Other | | | |

**Genetic Risk Assessment (Mark 'M' if Mother, 'F' Baby's Father or 'O' other)**

| Condition | M/F/O | Condition | M/F/O |
|---|---|---|---|
| Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly) | | Cystic Fibrosis | |
| Congenital Heart Defect | | Mental Retardation/Autism | |
| Down Syndrome | | Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU) | |
| Genetic Metabolic Disorder | | Recurrent Pregnancy Loss, or a Stillbirth | |
| Sickle Cell Disease or Trait | | Other Birth Defects | |
| Thalassemia | | Other Single Gene Disorders | |
| Hemophilia or Other Blood Disorders | | Consanguinity | |
| Muscular Dystrophy | | Other | |

**Surgeries & Hospitalizations***

| # | Date | Procedure | Diagnosis/Reason | Hospital Name |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

**Current Medications (Include any vitamins and herbal supplements)***

| | | | |
|---|---|---|---|
| 1 | | 4 | |
| 2 | | 5 | |
| 3 | | 6 | |

**Allergies (include all medication and non-medication allergies)***

| Allergen | Symptoms | Allergen | Symptoms |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Preferred Pharmacy***

| Name | Address | City | State | Zip Code | Telephone | Mail Order/Retail? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |



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Name: ______________________________
MRN: ______________ DOB: ______________

## Social History

Pt

Occupation ______________ Marital Status ______________

Father of Baby Name ______________ FoB/Partner Occupation ______________

**Exercise**

How often do you exercise per week? ______________ Type of Exercise ______________

**Alcohol/Smoking/Drug Use**

Do you smoke or use tobacco? ______ # of packs per day ______________ Years Smoked ______

Are you exposed to 2nd hand smoke at home or work? ______________

Do you consume alcohol? ______ # of drinks per day/week ______________ Type of alcohol ______________

Do you use recreational drugs? ______ # per day/week ______________ Type of drug(s) ______________

**Diet/Habits**

List any dietary restrictions ______________

Have you ever been threatened, abused or hurt by anyone?

Will you accept blood products in an Emergency? ______________

**Advanced Directives**

Do you have an advanced directive or living will? ______________

Do you have a durable power of attorney? ______________

Do you have a do not resuscitate document? ______________

## Gynecological History

Date of last menstrual period ______________ Age of 1st period ______________

Are your periods regular? ______________ How many days does your period last? ______________

When was your last pap smear? ______________ Have you ever had an abnormal pap smear? ______________

When was your last mammogram? ______________ Do you perform self breast exams? ______

Have you ever been treated for any of the following? (Circle)

Vaginosis Genital warts Chlamydia Herpes Trichomonas Gonorrhea Syphilis

Have you ever been tested positive for HIV? ______ Did your mother take DES when she was pregnant with you? ______



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