617 W. Division Street
Mount Vernon, WA 98273
P: (360)428-1884 F: (360)428-1889

OB INTAKE QUESTIONNAIRE

Please answer the following questions to the best of your ability, using the back of the page as needed.

DEMOGRAPHICS:

Today's Date:

Your Name:

Your Birthdate:

Your Age:

Your Race:

Religion:

Occupation:

Years of Education:

Marital Status:

Father of Baby/Partner (if applicable):

Father of Baby/Partner Phone Number:

Your Phone Number:

Your Full Address:

How did you hear about us (friend/physician name)?

Who is your primary care provider?

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GYNECOLOGICAL HISTORY

How old were you when you first got your period?

How many days do you have between periods (e.g. 28-30 days)?

Are your periods regular or irregular (i.e. occur around the same time each month, or seem to skip around)? (please circle) REGULAR or IRREGULAR

How many days do your periods typically last?

Have you ever had an abnormal PAP? (If yes, when?)

When was your last PAP?

Have you ever experienced infertility or undergone artificial insemination?

Have you ever had gynecological surgery (e.g. c-section, ablation, D&C, oophorectomy, etc.)? (If yes, when?)

Were you using hormonal contraception within 90 days of getting pregnant (e.g. birth control pills, IUD, etc.)?

Do you have a history of breast issues? What type?

Do you have any other notable gynecological issues? Please explain.

Have you or your partner ever been diagnosed with an STD (e.g. chlamydia, herpes, HPV, HIV, syphilis, gonorrhea, other)?

MEDICAL HISTORY

Have you ever had any significant issue (i.e. chronic condition, surgery, taking medication, etc.) with your:

- Head, Eyes, Ears, Nose Throat
- Cardiovascular/Heart
- Respiratory/Tuberculosis/Asthma
- Bowel/Gastrointestinal/Hepatitis
- Bladder/Genitourinary
- Metabolic/Thyroid
- Brain/Neuro
- Blood Clotting (Coagulation) Disorders
- Depression/Anxiety/Other Psych
- Musculoskeletal (i.e. broken bones, muscle issues)
- Skin Disorders
- Operations
- Transfusions
- Allergies (environmental or related to medication)

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- Latex or Iodine Allergy
- Sexual Abuse or Violence
- Other (please explain): _____

If you checked yes to any of the items above, please explain if you need more space, giving approximate date of any surgeries, diagnoses, etc.:

_____

_____

_____

_____

_____

OTHER HISTORY

For either you, the father of the baby/doner, or your immediate relatives, is there any history of:

- Diabetes? (If yes, who and what type: I or II?)
- Hypertension/High Blood Pressure? (If yes, who?)
- Twins? (If yes, who?)
- Congenital Anomalies (i.e. Down Syndrome, Cleft Lip/Palate, Spina Bifida, etc.)? (If yes, who? What type?)
- Any other pertinent family history?

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PREVIOUS PREGNANCIES

Starting with the first pregnancy, up to the current pregnancy, please list each time you have been pregnant. It is important to include every pregnancy (i.e. miscarriages, abortions, ectopic, stillborn, and live births).

No.	Date	Length of pregnancy (weeks)	Labor (hrs)	Type of delivery (VAG, C/S, miscarriage, abortion, ectopic pregnancy)	Anesthesia (Y or N)	Baby's Sex	Baby's Weight	Where Delivered and Which Doctor Delivered?	Complications?	Baby's Name
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										

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PRESENT PREGNANCY HISTORY

For this pregnancy:

What is the first date of your last period?

Was it a normal or abnormal period?

What is the first date of your last ***normal*** period?

Was this pregnancy planned/OK?

Is the father of the baby/your partner supportive (if applicable)?

Have you experienced (check all that apply):

- Nausea
- Vomiting
- Bleeding
- Urinary Symptoms (e.g. blood in urine, pain, etc.)
- Pain
- Vaginal Discharge
- Infection
- Fever
- Rash

Have you used tobacco or marijuana or been exposed to 2nd hand smoke?

Have you consumed alcohol?

Have you consumed/used drugs or medications that weren't prescribed for you (other than over the counter)?

Were you taking folic acid prior to getting pregnant?

Have you experienced any physical or sexual abuse/domestic violence?

Do you feel safe in your home?

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MEDICATIONS

Please list any medications that you are currently taking, including the dose and how often the medication is taken.

_____

_____

_____

Do you have any drug allergies or reactions to drugs? If so, what medication and what is the reaction?

_____

_____

Do you have any dietary restrictions or intolerances? If so, what are they?

_____

_____

Thank you for completing this form! Please bring this in to our clinic at least **2 days prior to your first appointment** with Dr. Benson to avoid being rescheduled. We will take a blood and urine sample when you drop this form off.

Congratulations on expecting your new little one!