SARATOGA HOSPITAL
MEDICAL GROUP
MIDWIFERY AND WOMEN'S HEALTH SERVICES

Obstetric Intake and History Form
Today's Date: _____

Name: _____ Date of Birth:_____

Social History:
Marital Status: _____
Partner's name and occupation (if involved):_____
With whom do you live?_____
Are you employed? If so, what is your occupation?_____

Do you use tobacco products? NO YES
Do you consume Alcohol? NO YES
Do you use Illicit Recreational Drugs? NO YES

Family History:
Does anyone in your immediate family (mother, father, siblings, and children) have a significant medical history such as diabetes, heart disease, or stroke? If so, please describe:_____

Your Medical History: (please describe any YES answers)
Are you currently taking any medications? NO YES_____
Do you have any allergies to medications? NO YES _____
When was your last physical exam?_____
When was your last gynecological exam?_____
When was your last pap smear?_____ was it normal? YES NO
Did you experience any childhood illnesses? NO YES
Have you experienced any accidents? NO YES
Have you ever been hospitalized? NO YES
Have you ever had a surgery? NO YES

Are you currently, or have you in the past, experienced any of the following conditions? (If you answer YES, please describe)

Diabetes	NO	YES	Trauma/Violence	NO	YES
Hypertension	NO	YES	History of Blood Transfusion	NO	YES
Heart Disease	NO	YES	D (Rh) Sensitized	NO	YES
Autoimmune Disease	NO	YES	Pulmonary (TB, Asthma)	NO	YES
Kidney Disease/UTI	NO	YES	Seasonal Allergies	NO	YES
Neurological/epilepsy	NO	YES	Breast Disease	NO	YES
Psychiatric Disorders	NO	YES	Anesthetic Complications	NO	YES
Depression/Anxiety	NO	YES	History of Abnormal Pap	NO	YES
Hepatitis/Liver Disease	NO	YES	Uterine Anomaly	NO	YES
Varicosities/Phlebitis	NO	YES	Infertility	NO	YES
Thyroid Dysfunction	NO	YES	Other _____		

OBSTETRIC HISTORY

When was you last menstrual period? _____

Was it "normal" (came when expected, usual length, usual flow)? _____
If no please explain: _____

Were you planning a pregnancy at this time? _____

Were you using a method of birth control when you conceived? _____

How many times have you been pregnant?	Have you had any miscarriages? If so, how many?	Have you had any abortions? If so, how many?
How many full term deliveries?	Have you had any still births? If so, how many?	Have you had an ectopic pregnancy? If so, how many?
How many pre-term deliveries (before 37 weeks)?	Any history of pre-term labor?	

Please list and provide information on past deliveries you may have had:

Date of Delivery	Sex	Weight	Length of Labor	Pre-Term Labor?	Vaginal or C-Section	Any complications with pregnancy or delivery? If yes please explain.

GENETIC HISTORY

(Patient, Baby's father or any Family member with)

Patient Age 35+	NO	YES
Thalassemia	NO	YES
Neural Tube defect	NO	YES
Congenital Heart defect	NO	YES
Down syndrome	NO	YES
Tay-Sachs disease	NO	YES
Canavan Disease	NO	YES
Sickle Cell disease	NO	YES
Hemophilia	NO	YES
Muscular Dystrophy	NO	YES

INFECTION HISTORY:

Have you been exposed to Hepatitis B? No Yes
Have you received the Hepatitis B Vaccination Series? No Yes
Any Exposure to Tuberculosis? No Yes
Patient or partner history of Genital Herpes? No Yes
Rash or viral illness since last menstrual period? No Yes
History of STD, GC, Chlamydia, HPV, Syphilis No Yes
Possible Exposure of Fifth's Disease? No Yes
History of Chicken Pox? NO YES
History of Chicken Pox vaccine? NO YES
History of MRSA? NO YES

Are you currently experiencing any of the following?

- Fever
- Weight Gain
- Weight Loss
- Rash
- Blurred Vision
- Heachache
- Bleeding gums
- Difficulty Breathing
- Breast Mass
- Chest Pain
- Fainting/Blacking Out
- Elevated Blood Pressure
- Shortness of Breath
- Abdominal Pain
- Constipation
- Nausea
- Vomiting
- Frequency in urination
- Painful urination
- Pelvic pain
- Vaginal bleeding
- Vaginal discharge
- Back pain
- Leg cramps
- Depression