



## New Client Intake

**Please answer the following questions to help us have a better understanding of your health history & enable us to provide the best prenatal care possible. This information is completely confidential. Requested demographic data is optional to share and collected for vital statistics for filling out the baby's birth certificate application only.**

Name: First		Middle	Last	Maiden?	Date	Phone (home) (work) (cell)	
Race	Religion	Yrs Educ	Marital Status	Occupation		Date of Birth	State/Country of Birth
Address: Street		City/State	Zip	Inside City Limits?		How long at this address?	
Partner:			Race	Yrs. Educ.	Date of Birth	State/Country of Birth	
Address (if different from above)				Phone (work/home/cell)		Occupation	
Father of Baby (if different than partner)			Emergency contact: Name Phone relationship				
Method of payment			Insurance information Name or policy holder Policy # Group #				
Social security #	Partner SS#	Email address(es)			Referred by:		

**FAMILY HISTORY-** *Indicate if anyone in your immediate family has ever had any of the below. If yes, who and when.*

- High Blood Pressure \_\_\_\_\_
- Heart Attacks \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Twins \_\_\_\_\_
- Birth Defects \_\_\_\_\_
- Cancer \_\_\_\_\_
- Mental Illness \_\_\_\_\_
- Alcohol/Drug Abuse \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Other: \_\_\_\_\_

**FATHER OF BABY-** *Indicate if the baby's father has ever had any of the below. If yes, when.*

- Sexually transmitted infections \_\_\_\_\_
  - Genital/Oral Herpes \_\_\_\_\_
  - Mental Illness \_\_\_\_\_
  - Alcohol/Drug Abuse \_\_\_\_\_
  - Tobacco use \_\_\_\_\_
  - Other \_\_\_\_\_
- Father's birth weight \_\_\_\_\_

**YOUR MOTHER'S HISTORY-**

*Please answer the following regarding your mother:*

- No. of pregnancies \_\_\_\_\_
- No. of births \_\_\_\_\_
- No. of Cesarean deliveries \_\_\_\_\_
- No. of premature births \_\_\_\_\_
- Miscarriages \_\_\_\_\_
- Complications \_\_\_\_\_
- Your birth weight \_\_\_\_\_
- Did she take DES when pregnant with you? \_\_\_\_\_
- Did she breastfeed you? \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### GENETIC HISTORY

- Yes No Have you had 2 or more pregnancies that ended in miscarriage?
- Yes No Has you or the father of the baby (FOB) ever had a still born baby or a baby with a birth defect (e.g. cleft palate, deafness, club foot, blindness, spina bifida) or mental retardation? If so, please describe: \_\_\_\_\_
- Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited (e.g. heart condition, muscular dystrophy, cystic fibrosis, hemophilia, sick cell disease)? If so, please explain: \_\_\_\_\_
- Yes No Have you or the FOB had a child that died around the time of birth or in the first year of life? If so, please explain: \_\_\_\_\_
- Yes No Are you and the FOB related by blood? (e.g. cousins)
- Yes No Are you or the FOB from any of the below racial or ethnic groups? (Circle)  
 Jewish Black/African Asian French Canadian Mediterranean(Greek, Italian, Other)
- Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

**MEDICAL HISTORY** Please indicate if you have ever had any of the below. If yes, when.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Severe headaches _____        | <input type="checkbox"/> Hemorrhoids _____           | <input type="checkbox"/> Diabetes _____                  |
| <input type="checkbox"/> Eye/Vision problems _____     | <input type="checkbox"/> Tuberculosis _____          | <input type="checkbox"/> Hypoglycemia _____              |
| <input type="checkbox"/> Ear/Hearing problems _____    | <input type="checkbox"/> Asthma _____                | <input type="checkbox"/> Bladder infection _____         |
| <input type="checkbox"/> Dental problems _____         | <input type="checkbox"/> Skin disorders _____        | <input type="checkbox"/> Kidney infection _____          |
| <input type="checkbox"/> Thyroid problems _____        | <input type="checkbox"/> Stomach problems _____      | <input type="checkbox"/> Arthritis _____                 |
| <input type="checkbox"/> Rheumatic fever _____         | <input type="checkbox"/> Ulcers _____                | <input type="checkbox"/> Pelvic or back injuries _____   |
| <input type="checkbox"/> Blood clotting problems _____ | <input type="checkbox"/> Bowel problems _____        | <input type="checkbox"/> Seizures _____                  |
| <input type="checkbox"/> Heart problems _____          | <input type="checkbox"/> Blood in stool _____        | <input type="checkbox"/> Cancer _____                    |
| <input type="checkbox"/> Anemia _____                  | <input type="checkbox"/> Chicken Pox _____           | <input type="checkbox"/> Hospitalizations _____          |
| <input type="checkbox"/> Hemorrhage _____              | <input type="checkbox"/> Gall bladder problems _____ | <input type="checkbox"/> Surgeries _____                 |
| <input type="checkbox"/> High blood pressure _____     | <input type="checkbox"/> Liver problems _____        | <input type="checkbox"/> Blood transfusions _____        |
| <input type="checkbox"/> Varicose veins _____          | <input type="checkbox"/> Hepatitis _____             | <input type="checkbox"/> Mental Illness/Depression _____ |
|  |  | <input type="checkbox"/> Other _____                     |

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies (drug or environmental)? Yes No Please list and describe severity & type of reaction: \_\_\_\_\_

Are you currently regularly taking any prescription medications? Yes No Please list and describe (name, dosage, frequency, reason for taking): \_\_\_\_\_

Are you currently taking any over-the-counter medications? Yes No Please list and describe: \_\_\_\_\_

Are you currently taking any supplements, herbs or natural medicines? Yes No Please list and describe: \_\_\_\_\_

Are you currently under the care of a physician or other health care provider(s) (including alternative care such as chiropractic, homeopathy, acupuncture, massage etc)? Yes No If yes, please list and describe (name & type of provider, reason for care, length of time in care, etc.) \_\_\_\_\_

Do you exercise regularly? Yes No If yes, please describe the type of exercise, how often, for how long, etc. \_\_\_\_\_

Do you meditate, pray or do yoga? Yes No \_\_\_\_\_

Are you pleased with your eating habits? Yes No What "type" of diet would you say you are on? (lacto-ovo vegetarian, vegan, meat eater, etc.)? \_\_\_\_\_

**GYNECOLOGIC HISTORY**

Age at first period \_\_\_\_\_ How many days do you flow? \_\_\_\_\_ How long is your cycle (days) \_\_\_\_\_ Is your cycle regular? Yes No

Pain/Cramping? Yes No Emotional Symptoms? Yes No Do you know when you ovulate? Yes No

When was your last Pap Smear? \_\_\_\_\_ Have you ever had an abnormal Pap? (Dates) \_\_\_\_\_ Please describe \_\_\_\_\_

Do you examine your breasts? Yes No How often? \_\_\_\_\_ Do you douche? Yes No

Please indicate if you have ever had any of the following. If yes, when.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Yeast infections _____     | <input type="checkbox"/> Genital sores _____        | <input type="checkbox"/> Endometriosis _____      |
| <input type="checkbox"/> Trichomonas _____          | <input type="checkbox"/> Herpes: Oral Genital _____ | <input type="checkbox"/> Abnormal Bleeding _____  |
| <input type="checkbox"/> Group B Strep _____        | <input type="checkbox"/> HPV or Genital Warts _____ | <input type="checkbox"/> Uterine Surgery _____    |
| <input type="checkbox"/> Bacterial vaginosis _____  | <input type="checkbox"/> Cervicitis _____           | <input type="checkbox"/> Breast lump(s) _____     |
| <input type="checkbox"/> Chlamydia _____            | <input type="checkbox"/> Cervical surgery _____     | <input type="checkbox"/> Breast surgery _____     |
| <input type="checkbox"/> Gonorrhea _____            | <input type="checkbox"/> Cervical polyp _____       | <input type="checkbox"/> Fertility problems _____ |
| <input type="checkbox"/> Syphilis _____             | <input type="checkbox"/> Ovarian Cyst _____         | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> PID/pelvic infection _____ | <input type="checkbox"/> Fibroids _____             |   |

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS PREGNANCIES** Please fill out table regarding your own pregnancies (from earliest to most recent).

Date Ended (DOB)	# Weeks	Hospital/ Home/BC?	Comments (if birth: type of delivery?; weight and sex and name of baby; medications/intervention; length of labor, complications, length of breastfeeding etc.; if miscarriage or termination, note complications, type of procedure or surgery, if any)

**PRESENT PREGNANCY**

First day of last menstrual period (LNMP) \_\_\_\_\_ Normal? Yes No Sure of LNMP? \_\_\_\_\_  
 Suspected date of conception \_\_\_\_\_ Pregnancy test (date) \_\_\_\_\_ Planned pregnancy? Yes No  
 When do you think your baby will be born? \_\_\_\_\_  
 Feelings about pregnancy \_\_\_\_\_  
 Father and/or partner's feelings about pregnancy \_\_\_\_\_  
 Most recent birth control used \_\_\_\_\_ Contraception used in past; what, when, any problems? \_\_\_\_\_

*Please indicate if you have had any of the below problems during this pregnancy:*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Nausea _____      | <input type="checkbox"/> Swelling _____                            | <input type="checkbox"/> Varicose veins _____                        |
| <input type="checkbox"/> Vomiting _____    | <input type="checkbox"/> Constipation _____                        | <input type="checkbox"/> Hemorrhoids _____                           |
| <input type="checkbox"/> Fever _____       | <input type="checkbox"/> Diarrhea _____                            | <input type="checkbox"/> Depression _____                            |
| <input type="checkbox"/> Infections _____  | <input type="checkbox"/> Non-food cravings (e.g. dirt, soap) _____ | <input type="checkbox"/> Loneliness _____                            |
| <input type="checkbox"/> Headache _____    | _____  | <input type="checkbox"/> Family/relationship problems _____          |
| <input type="checkbox"/> Dizziness _____   | <input type="checkbox"/> Urinary complaints _____                  | _____  |
| <input type="checkbox"/> Indigestion _____ | <input type="checkbox"/> Abdominal/pelvic pain _____               | <input type="checkbox"/> Work problems _____                         |
| <input type="checkbox"/> Leg cramps _____  | <input type="checkbox"/> Vaginal bleeding/spotting _____           | <input type="checkbox"/> Electric blanket/heating pads/H2O bed _____ |
| <input type="checkbox"/> Rash _____        | <input type="checkbox"/> Vaginal discharge _____                   | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Backache _____    | <input type="checkbox"/> Bleeding gums _____                       | _____  |

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Please indicate if you have used, experienced, or been exposed to any of the below during this pregnancy:*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Tobacco _____      | <input type="checkbox"/> Non-pres. Drugs _____         | <input type="checkbox"/> Mercury _____      |
| <input type="checkbox"/> Alcohol _____      | <input type="checkbox"/> Vitamins _____                | <input type="checkbox"/> Lead _____         |
| <input type="checkbox"/> Caffeine _____     | <input type="checkbox"/> Herbs _____                   | <input type="checkbox"/> Vaccinations _____ |
| <input type="checkbox"/> Marijuana _____    | <input type="checkbox"/> Fumes/Sprays/Pesticides _____ | <input type="checkbox"/> Travel _____       |
| <input type="checkbox"/> Cocaine _____      | <input type="checkbox"/> X-rays _____                  | <input type="checkbox"/> Cats _____         |
| <input type="checkbox"/> Street drugs _____ | <input type="checkbox"/> Ultrasound _____              | <input type="checkbox"/> Raw meat _____     |
| <input type="checkbox"/> Other meds _____   | <input type="checkbox"/> Measles/Viruses _____         | <input type="checkbox"/> Other _____        |

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_