

ADEFRIS AND TOPPIN WOMEN'S SPECIALISTS PRENATAL INTAKE
(please print)

Date _____

Patient Name _____

Date of birth _____

Allergies to medication or latex _____

If yes, please describe reaction _____

Medications you are using _____

Menstrual History

How old were you when you first got your period? _____

How long does your period last? (i.e. 3-5 days) _____

How many days between your period (i.e. 28 days) _____

What was the first day of your last period? _____

Have you ever had an abnormal pap smear? _____

If yes, did you have a colposcopy, LEEP, or cryo surgery? _____

Pregnancy History

How many times have you ever been pregnant, including this pregnancy? _____

How many babies were > 37 weeks gestation? _____

How many babies were < 37 weeks gestation? _____

How many miscarriages have you had? _____

How many ectopic pregnancies have you had? _____

How many abortions have you had? _____

How many sets of twins/triplets have you had? _____

How many living children do you have? _____

Have you had an ultrasound during this pregnancy? _____

If yes, when, where and due date given? _____

Past Pregnancy History

Date	Weeks	Length of Labor	Birth Wt	Sex	Delivery (vaginal/c-section)	Complications
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Will you be 35 years of age or older when your baby is born? _____

Medical History

If **you** or any **close relative** have any of these medical problems please circle "yes". Circle "no" if condition does not apply. For the following questions close relatives are considered to include the grandparents, parents, aunts, uncles, first cousins, brothers, sisters, or children of you and the baby's father.

If you answer yes to any question please indicate who is affected.

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|--|-----|----|
| 1 child with known birth defect (heart defect, cleft lip/palate, club foot) | Yes | No |
| 2 chromosome abnormalities (Down Syndrome, Turner Syndrome, Klinefelter Syndrome) | Yes | No |
| 3 abnormalities of the brain or spinal column (hydrocephalus, spina bifida meningomyelocele, microcephalus, mental retardation, etc) | Yes | No |
| 4 abnormalities of the bones or skeleton (osteogenesis imperfecta, dwarfism limb deformities, achondroplasia, etc.) | Yes | No |
| 5 neuromuscular disorders (muscular dystrophy, myotonic dystrophy) | Yes | No |
| 6 metabolic or chemical disorders (Tay-Sachs Disease, cystic fibrosis Thyroid Disease) | Yes | No |
| 7 skin disorders | Yes | No |
| 8 hereditary visual or hearing defects | Yes | No |
| 9 unusual reactions to anesthetic agents | Yes | No |
| 10 other inherited genetic diseases not listed above (e.g., Huntington's chorea, polycystic kidney, congenital adrenal hyperplasia, etc) | Yes | No |
| 11 Diabetes | Yes | No |
| 12 Were you ever on a special diet as a child or do you know of a family member with PKU (phenylketonuria) | Yes | No |
| 13 Hepatitis or liver disease | Yes | No |
| 14 Depression, post partum depression, or anxiety | Yes | No |
| 15 Varicose veins, phlebitis, deep venous thrombosis, blood clots | Yes | No |
| 16 Thyroid dysfunction | Yes | No |
| 17 Have you ever been physically, sexually, emotionally abused?
If yes, are you safe now? | Yes | No |
| 18 History of blood transfusion | Yes | No |
| 19 Seasonal allergies | Yes | No |
| 20 Heart disease (i.e., stroke, heart attack, etc) | Yes | No |
| 21 Any blood disorders (sickle cell anemia, thalassemia, lymphoma Leukemia) | Yes | No |
| 22 Cancer (breast, colon, ovarian, cervical, etc) | Yes | No |
| 23 History of surgery (tonsillectomy, cesarean section, etc) | Yes | No |
| 24 Sexually transmitted disease (HPV, herpes, gonorrhea, chlamydia) | Yes | No |
| 25 Chicken Pox | Yes | No |
| 26 Infertility | Yes | No |
| Please explain | | |

27 Any other medical history we should know about?

Are you or the baby's father of the following racial backgrounds?

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|---|--------|
| 1 Jewish (Eastern European, Mediterranean, or French Canadian?) | |
| If yes, have you ever been tested for Tay-Sach's? | Yes No |
| 2 Italian, Greek, or Mediterranean? | |
| If yes, have you ever been tested for Beta-Thalassemia? | Yes No |
| 3 Southeast Asian or Filipino? | |
| If yes, have you ever been tested for Alpha/Beta Thalassemia? | Yes No |
| 4 African? | |
| If yes, have you ever been tested for Sickle cell? | Yes No |
| 5 Northern European, Jewish, French Canadian? | |
| If yes, have you ever been treated for Cystic Fibrosis? | Yes No |
| 6 Are you and the father of the baby related? | Yes No |

Nutrition

- | | |
|--|--------|
| Are you on a special diet? | Yes No |
| Do you have a history of an eating disorder? | Yes No |
| Do you often skip meals? | Yes No |
| Are you currently taking a prenatal vitamin? | Yes No |
| Are you vegetarian/vegan? | Yes No |

Exposure

- | | |
|--|--------|
| Do you have pets? | Yes No |
| Are you exposed to harmful chemicals or radiation at work? | Yes No |
| Do you smoke? | Yes No |
| If yes, how many cigarettes do you smoke in a day? _____ | |
| Do you drink alcohol? | Yes No |
| If yes, how many drinks do you consume in a week? _____ | |
| Do you use street drugs? (i.e. marijuana, methamphetamine, cocaine, etc) | Yes No |