

INTAKE FORM

Client Full Name _____ **Maiden Name** _____

Address(include City/Twnshp &County): _____

State/Country Born In: _____ SS#: _____

DOB: _____ Occupation: _____ Education Level: _____

LMP: _____ EDD: _____ Married? _____

Ancestry: _____

of Prenatals Before Engaging My Services: _____

Type of Practitioner Seen: _____

Procedures Performed (Ultrasound, genetic/prenatal testing): _____

Number of Previous Pregnancies: _____ Month/Year of Last Live Birth: _____

Partner Full Name _____

SS# _____ Occupation: _____

State/Country Born In: _____ DOB: _____

Education Level: _____ Ancestry: _____

MEDICAL HISTORY

Name: _____ Due Date: _____

G ___ T ___ P ___ Ab ___ L ___ LMP: _____

Blood Type: _____ Height: _____ Pre-Pregnancy Weight: _____

Check if you've *ever* had problems with any of the following:

<input type="checkbox"/> Severe headaches	<input type="checkbox"/> Bowels	<input type="checkbox"/> Allergies
<input type="checkbox"/> Eye/Vision	<input type="checkbox"/> Colitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Ear/Hearing	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Hospitalizations
<input type="checkbox"/> Dental	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Liver	<input type="checkbox"/> Stomach
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood clotting	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Respiratory ailments
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Drug reactions
<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Bladder infection	<input type="checkbox"/> Heart disease
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney infection	<input type="checkbox"/> Eating disorders
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Urinary surgery	<input type="checkbox"/> Drug/alcohol abuse
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Urethral dilation	<input type="checkbox"/> Psychological issues
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sexual/physical abuse	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____	

Gynecological History: *(if yes, when?)*

<input type="checkbox"/> Yeast _____	<input type="checkbox"/> Bacterial vaginosis _____
<input type="checkbox"/> Chlamydia _____	<input type="checkbox"/> Gonorrhea _____
<input type="checkbox"/> Syphilis _____	<input type="checkbox"/> Pelvic inflammatory disease _____
<input type="checkbox"/> Genital Sores _____	<input type="checkbox"/> Herpes: ___genital ___oral
<input type="checkbox"/> Trichomonas _____	<input type="checkbox"/> Genital warts _____
<input type="checkbox"/> Cervicitis _____	<input type="checkbox"/> Cervical surgery _____
<input type="checkbox"/> Cervical polyp _____	<input type="checkbox"/> Ovarian cyst _____
<input type="checkbox"/> Fibroids _____	<input type="checkbox"/> Endometriosis _____
<input type="checkbox"/> Gardnerella _____	<input type="checkbox"/> Abnormal bleeding _____
<input type="checkbox"/> Uterine surgery _____	<input type="checkbox"/> Breast Lump(s) _____
<input type="checkbox"/> Infertility _____	<input type="checkbox"/> Breast surgery _____
<input type="checkbox"/> Other _____	

Present Pregnancy: *(please indicate if you've had any of the following problems during this current pregnancy)*

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Unusual cravings | <input type="checkbox"/> Vaginal bleeding/spotting |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Backache | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Swelling | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Constipation | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Urinary complaints | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Vaginal infection |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Abdominal/pelvic pain |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Family issues | <input type="checkbox"/> Work issues |
| <input type="checkbox"/> Too rapid weight gain | | |

When was your last Pap/pelvic exam? _____ Normal? _____

Cycle length: _____ Regular: _____

When was your last breast exam? _____ Normal? _____

Do you self breast exam? _____

Are you planning to breastfeed? _____

Do you have flat or inverted nipples? _____

Father of Baby: *(please indicate if father of baby has ever had any of these & when)*

Sexually transmitted disease(s) _____

Urethritis _____ Herpes: genital oral

Severe emotional problems _____

Alcohol/drug abuse _____

Tobacco use _____

Family History: *(please indicate if anyone in your immediate family has ever had any of these. who? when?)*

High blood pressure _____ Cancer _____

Diabetes _____ Twins _____

Hereditary disease(s) _____

Birth defects _____

Severe emotional problems _____

Alcohol/drug abuse _____

Your Mother's History:

Number of pregnancies: _____ Number Live Births: _____

Miscarriages: _____ Any complications: _____

Your birth weight: _____ Did she take DES while pregnant with you? _____