HealthCare Partners
Ph: (702) 255-3547
● Fx: (702) 736-2831

Patient Label

OB – Women's Health Patient Intake History

Patient Name _____ **Birthdate** _____ / _____ / _____ **Today's Date** _____ / _____ / _____

☐ English ☐ Spanish ☐ Sign Language ☐

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Are you living alone? ☐ Yes ☐ No

Primary Language: Other: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired **Occupation**: _____

Tobacco Use: ☐ Yes ☐ No | **If yes, how much/how long (yrs)** _____ | ☐ Never a smoker ☐ Former smoker | How Long _____

Alcohol Use: ☐ Yes ☐ No | **If yes, how much/how often** _____ | **Drug Use**: ☐ Yes ☐ No | If yes, how long _____

Patient History

Current Medications (include prescriptions, vitamins, supplements, and over the counter medications), Attach separate sheet if needed:

Name & Strength of Rx	*Reason for Rx*	*Prescribing Physician*	*Date Prescribed*

Allergies

Do you have any allergies? ☐ Yes ☐ No ☐ ☐

Do you have a latex allergy? Yes No | Reaction: _____

Allergy: _____ | Reaction: _____

Allergy: _____ | Reaction: _____

Allergy: _____ | Reaction: _____

Vaccines

Please tell us when you last had the following immunization(s):

Flu:	**Pertussis (Whopping Cough):**
Chicken Pox (disease or vaccine):	**HPV:**

Other: _____

Medical History

What medical problems have you had? Please mark all that apply:

✓	Condition	Onset Date	✓	Condition	Onset Date	✓	Condition	Onset Date
	Allergies			Diabetes			Trauma/Violence	
	Anemia/Hematologic			Heart Disease/ Stroke			Uterine Abnormalities	
	Asthma/ Pulmonary			Hypertension			Varicosities/ Blood clots	
	Autoimmune Disorder			Infertility			Anesthesia Complications	
	Abnormal Pap Smears			Liver Disease			Cancer	

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	Blood Transfusions			Neurologic Disorder Epilepsy/Headache/Migraine			*Other:*	
	Breast Disorders			GI/Stomach Kidney/Bladder				
	Depression/ Psychiatric			Rh Sensitized				
	Skin Disorder			Thyroid Disorder				

Surgical History

Please list any surgeries you have had:

Date:	Surgery:	Date:	Surgery:

Infection History

Have you or do you currently have any of the following? Please mark all that apply:

✓	Condition	✓	Condition	✓	Condition
	Chicken Pox		Hepatitis B or C		Sexually Transmitted Infection
	Chlamydia		HIV		Syphilis
	Genital Herpes (you or partner)		Human Papilloma Virus (HPV)		Tuberculosis (you or family)
	Gonorrhea		Rash or Viral illness since LMP		Other: _____

Pregnancy History

Number of Pregnancies _____ Number of Births _____ Number of Full Term Births _____

Number of Pre-Term Births _____ Number of Abortions _____ Number of Miscarriages _____

Number of Living Children _____ Number of Cesarean Sections _____

Provider Use: G__ P __ __ __ __ __

Date of last menstrual period: _____ / _____ / _____ Due Date if known _____ / _____ / _____

Have you been in the ER since LMP? ☐ Yes ☐ No Have you had an ultrasound? ☐ Yes ☐ No

Have you seen another provider? ☐ Yes ☐ No | If yes, when? _____ Is this a planned pregnancy? ☐ Yes ☐ No

Were you using hormonal contraception within 2 months of your last menstrual period? ☐ Yes ☐ No

Were you breastfeeding when you became pregnant? ☐ Yes ☐ No

Did pregnancy result from infertility treatment? ☐ Yes ☐ No | If yes, method used: _____

Please list all of your pregnancies with details below (live births, miscarriages, ectopic, abortions, etc.):

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Delivery Date/Time	# Weeks at Birth	Type of Delivery (Vaginal or C-Section)	Child's Sex	Child's Weight	Delivery Hospital	Mother/Baby Complications

Family History

List health conditions for each family member:

Family Member	Alive	Deceased	Age at time of Death	Health Condition(s)
Father				
Mother				
Brothers				

Family Member	Alive	Deceased	Age at time of Death	Health Condition(s)
Sisters				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Genetic History

Patient's Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Other: _____

Will you be 35 years old or older at the time the baby is born? ☐ Yes ☐ No

Will the father be 50 years old or older at the time the baby is born? ☐ Yes ☐ No

☐ Family history unknown

Please check if any family members (both you and baby's father's side of family) have had any of the following conditions:

☐ Patient adopted; no known family history

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Condition	Self	Baby's Father	Other Blood Relative	Comments
Birth Defect				
Canavan Disease				
Congenital Heart Defect				
Cystic Fibrosis				
Down's Syndrome				
Hemophilia				
Huntington's Chorea				
Maternal Metabolic Disorders				
Mental Retardation/Fragile X				
Muscular Dystrophy				
Neural Tube Defect				
Recurrent Pregnancy Loss or Stillbirth				
Sickle Cell Disease				
Tay Sachs				
Thalassemia				
Other:				

Anesthesia/Sedation History

Have you ever had general anesthesia? ☐ Yes ☐ No | If yes, list any reactions: _____

Have you ever had sedation for a procedure? ☐ Yes ☐ No

Have you ever had an epidural/spine ☐ Yes ☐ anesthesia? No | If yes, list any reactions:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of Healthcare Partners responsible for any errors or omissions that I may have made in the completion of this form.

_____

Patient or Parent/Guardian Printed Name

_____ _____

Patient or Parent/Guardian Signature Today's Date