WAYNE STATE UNIVERSITY
PHYSICIAN GROUP

OB Intake

Patient: _____

Date: ___/___/_____

Gestational Age

Last Period____/_____/_____

- Definite
- Approx (month Known)
- Unknown

Regular Periods? **Yes** **No**

Were you taking the Pill when you got pregnant? **Yes** **No**

List all medications taken since last period

_____ _____ _____

_____ _____ _____

_____

Medical Summary

Pregnancy History

Total Pregnancies☐ #Premature☐ #C-Section☐ #Living☐ #Aborted☐ #Miscarriage☐

Delivered Pregnancy # **1**

Sex: M F Delivery Type: **Vaginal** or **C-section**

Year of Delivery_____ Breech (bottom 1st)? **Yes** **No** **Hospital** _____

Gestational Age (months / weeks) at Delivery _____ Birth weight: _____lbs_____ounces

Delivered Pregnancy # **2**

Sex: M F Delivery Type: **Vaginal** or **C-section**

Year of Delivery_____ Breech (bottom 1st)? **Yes** **No** **Hospital**_____

Gestational Age (months/ weeks) at Delivery _____ Birth weight: _____lbs_____ounces

Delivered Pregnancy # **3**

Sex: M F Delivery Type: **Vaginal** or **C-section**

Year of Delivery_____ Breech (bottom 1st)? **Yes** **No** **Hospital**_____

Gestational Age (months/ weeks) at Delivery _____ Birth weight: _____lbs_____ounces

Please request, additional Forms available for more than 3 pregnancies

Medical Summary cont.

Did you have any complications/ problems with any of your other pregnancies? **Yes** (see ↓) **No**

Preg # ___ Problem_____ Dr. _____ Hospital_____

Outcome_____ Year/Date _____

Preg # ___ Problem_____ Dr. _____ Hospital_____

Outcome_____ Year/Date _____

Medical History

Pre-pregnancy **Smoking** Amts: _____cigs/day

Current **Smoking** Amts: _____cigs/day

Pre-Pregnancy **Alcohol** Amt: _____drinks/week

Current **Alcohol** Amt: _____drinks/week

Pre Preg. Street **Drugs**
Type:_____ Amt: _____/week

Current Street **Drug** Use
Type_____ Amt: _____/week

Infection History

Live w/someone w/Tuberculosis (lung disease) or exposed to TB? **Yes** **No**

You or partner has ever had genital herpes? **Yes** **No**

Rash or viral illness since last period? **Yes** **No**

Ever had Hepatitis B, C ? **Yes** **No**

History Sexually Transmitted Disease? **Yes**↓ **No**

HPV Gonorrhea HIV Chlamydia Syphilis _____

OB Social

Mother's race:_____

Baby's Father's
Name_____

Baby's father race _____

Support person's name_____

Prenatal classes? **Yes** **No**

Feeding: **Breast** **Bottle** **Both**

Desires sterilization after birth? **Yes** **No**
Enrolled in WIC prenatal care? **Yes** **No**

Anyone smoke in your home? **Yes** **No**

Are there any additional questions, concerns or comments you would like to discuss or mention?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____