Capital Health
Trenton, NJ

Maternal Fetal Medicine
Intake History

NAME:___________________________

PLEASE COMPLETE ALL PAGES AND RETURN FORMS TO THE FRONT DESK

Have you been here with another name? ____

Husband or Significant Other's Name:____

Home Address:____

____

HOME PHONE: ___________________________________

May we call you at home? ___Yes ___No

May we leave a message With medical information at home? ___Yes ___No

WORK PHONE: ___________________________________

May we call you at work? ___Yes ___No

May we leave a message for you to contact us? ___Yes ___No

CELL PHONE: ___________________________________

May we call you on your cell phone? ___Yes ___No

May we leave a message with medical information? ___Yes ___No

Who is your doctor? ____

Where do you go for prenatal care (which office)?__________________________________

If you are a Health Start patient, who is your case manager/nurse?_____________________

Are you allergic to any medications? Yes No

If yes, what? ____

Are you allergic to iodine?_____ Yes ______ No

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Race:____________________________ Weight: __________________________

Are you currently taking any medications other than prenatal vitamins or iron? ____Yes ____ No

If Yes, What? ____

INCLUDING THIS PREGNANCY, how many times have you been pregnant? _____ How old will you be on your due date? _______

Number of live births_____ Number of stillbirths_____ Number of tubal pregnancies_____

Number of miscarriages_____ Number of abortions_____ Number of living children_____

PLEASE TELL US ABOUT EACH OF YOUR PREVIOUS PREGNANCIES:

What year did the pregnancy end (when did you deliver?)	How far pregnant were you when you delivered?	Birth weight and Sex of baby (if known)	Vaginal birth? Cesarean birth? D & C? Miscarriage?	If C-birth, Why?	Complications during the pregnancy?	Complications during delivery?

	YES	NO
Do you have a history of infertility?		
Did you have infertility treatment to become pregnant this time?		
Have you had a prior ultrasound with this pregnancy?		

If yes, where? ____ when? ______________________

When was the first day of your last menstrual period? ______________________

When is your due date?__________________________

Please describe any problems you have had during this pregnancy :____

____

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Do you have a disability (sight, hearing, walking, learning, etc.)?______yes ______no

If yes, what accommodation is needed? ____

How do you prefer to receive medical information? _____verbal ____written ____no preference

What language is best? ____English ____Spanish ____Other_____________________________

Do you have any cultural beliefs that we should be made aware of? _____ Yes _____ No

If yes, please explain____

Is there anything else we should know about you? _____Yes _____ No

If yes, what?____

FOR STAFF USE ONLY: Reviewed by:_________________________________ Date:__________ Time: _______
Name/Credentials

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Health Information For Consultation

PLEASE CHECK ALL THAT APPLY or MARK N/A for Not Applicable	YOU	YOUR FAMILY	BABY'S FATHER	HIS FAMILY
Birth defects (cleft lip/palate, club foot, heart defect, etc.)				
Child or baby who died				
Baby with surgery or special medical care				
Genetic disease (cystic fibrosis, sickle cell, thalassemia, etc.)				
Gene carrier for genetic disease (cystic fibrosis, sickle cell, etc.)				
Mental retardation or learning disabilities				
Chromosome abnormality (translocation, trisomy, Down Syndrome, etc.)				
More than two (2) miscarriages				
Any stillborn baby				
Pregnancy interrupted due to fetal birth defects				

PLEASE CHECK ALL THAT APPLY TO YOU	YOU	PLEASE CHECK ALL THAT APPLY	YOU
Lung problems (asthma, pneumonia, bronchitis, etc.)		Liver problems (hepatitis, jaundice)	
Heart problems (heart attack, heart surgery, heart disease, etc.)		Rheumatoid arthritis	
High blood pressure		Kidney problems (bladder/kidney infections, etc.)	
Thyroid problems (goiter, underactive or overactive)		Gynecologic problems(vaginal infections, abnormal Paps)	
Diabetes Type I O Type II O Gestational O		Seizures	
Blood clots, stroke, aneurysm		Depression	
Cancer		Migraines	
Lupus or multiple sclerosis		Operations	
Anemia, bleeding disorder		Trauma/Major accidents or injuries	
Varicose veins, phlebitis		Other	

What is your family's racial and ethnic group?____

What is the father of the baby's racial and ethnic group? ___________________________________

Have you had sexually transmitted diseases (chlamydia, herpes, syphilis, gonorrhea, HIV, AIDS)? ____________________

Have you had chicken pox? _____ How old were you? _____ Did you have the vaccine? _____ If yes, when? ________________

Have you had Measles or German measles? ____ How old were you? _____ Did you have the vaccine? ____ If yes, when? ________

When did you start taking prenatal vitamins? ____

Since your last normal period, WHAT medications have you taken and WHY? ____

____

Cigarettes: I don't smoke _________________ I quit smoking on (date) _______________

I smoke ____ packs daily I smoke occasionally __________

Before I knew I was pregnant, I drank alcohol
_____ rarely (How many drinks per month? _____)
_____ occasionally (How many drinks per week? _____)
_____ daily (How many drinks per day? _____)
_____ never

Now, I drink alcohol
_____ rarely (How many drinks per month? _____)
_____ occasionally (How many drinks per week? _____)
_____ daily (How many drinks per day? _____)
_____ never

Which medicines or drugs have you used in the past 12 months? ____

Do you have a disability (sight, hearing, walking, learning, etc.)? _____Yes _____ No If yes, what accommodation is needed?

____

How do you prefer to receive medical information? ____verbal ___written ___no preference

What language is best? ___English ___ Spanish ___Other ____

Do you have transportation to future appointments, if necessary? Yes No

Do you have any cultural beliefs that we should be made aware of? Yes No If yes, what ________________________________

Are there other preferences of which we should be aware? ____

Do you have religious beliefs that we should be aware of when caring for you? ____

How do you feel about being pregnant?

_____happy _____ surprised _____ contemplating abortion _____ sad _____ neutral ____other ____________

Is the father of the baby involved with the pregnancy? ____

Are your family and/or friends supportive of you and the pregnancy? ____

Is there anything else we should know about you? Yes No If yes, what?____

____

____

FOR STAFF USE ONLY: Blood Type and Rh Factor: ___________________________

Red Blood Cell Antibody Screen: negative / positive

Chlamydia and gonorrhea cervical cultures: negative / positive

Risk Factor Identified: Yes_____ No _______ ___________________________ ____________ _______

RN signature/Credentials Date Time