NEW OB INTAKE FORM

Proponent for this form is MCXC-OB

Please circle or fill in the blanks as it applies

Name:____ Date of Birth:_________________ Age: __________

Current Phone Number: ____________________________ Highest Level of Education: ____________________

Occupation: ____

Height: _______________________Weight Before Pregnancy (pounds): _______________________

Allergy Information (Are You allergic to anything?): Medications, Foods, Latex, Plants

ALLERGY TYPE	NAME	SYMPTOMS	ONSET	SEVERITY

Current Medications, Herbals, Over the Counter Medications you are currently taking

Medication Name	Dose	Medical Condition	Last time taken

Social History

Do you use any tobacco products? ☐ YES / ☐ NO (Cigarettes, Cigars, Vapor products, Marijuana, Chewing tobacco)

If so, how long _________ and how often _________ *(ex: ½ PPD x 3 years)* Do you want to quit? ☐ YES / ☐ NO

Do you drink alcohol? ☐ YES / ☐ NO, How often? ____

Do you use illicit drugs? ☐ YES / ☐ NO, ____

STD HISTORY: (Circle and mark the month and year)

◯ Gonorrhea _______, ◯ Chlamydia_______, ◯ Syphilis_______, ◯ HPV_______, ◯ Herpes_______, ◯ HIV_______

Spouse/Significant other History of Herpes? ☐ YES / ☐ NO, ________________________________

CURRENT PREGNANCY ☐ Planned / ☐ Unplanned

Where you on birth control at time of Pregnancy? ☐ YES / ☐ NO, ________________________________

Spouse/Father of the baby Ethnicity: ________________________________

Spouse/Father of the baby Age: ________________________________

OBSTETRIC HISTORY

Age at 1st menstrual Period ____________________________ Years old

First day of your Last Menstrual Period __________________________ ☐ Sure / ☐ Unsure

Expected Delivery Date: _______________________ Weeks pregnant: ______________________

Is your due date based on ◯ Last Menstrual Period ◯ Ultrasound date

◯ In-Vitro Fertilization ◯ Intra Uterine insemination

Were donor eggs used? ☐ YES / ☐ NO, If yes age of donor ____________________________________

How many times have you been pregnant, INCLUDING THIS ONE? ____________________________________

How many Living Children? ___________ How many delivered early (before 37 weeks?) __________________

Have you ever had a Miscarriage? ☐ YES / ☐ NO, If so, when and how many weeks? _____________

Have you ever had an elective abortion? ☐ YES / ☐ NO, If so, when? _________________________

Have you ever had a D&C? ☐ YES / ☐ NO, If so, when? ______________________________________

Have you ever had a blood transfusion? ☐ YES / ☐ NO, Any adverse reactions? ________________

If you need blood products would you accept them? ☐ YES / ☐ NO, If not, why? ________________

Religious Preference ____

Do you plan to breastfeed? ☐ YES / ☐ NO

Please give history of ALL your pregnancies to include LIVE births and any type of loss, in numerical order

PRENATAL HISTORY (IF ANY):

Pregnancy 1: ☐ Male or ☐ Female

Delivery Date ________________________

Weeks Pregnant ____________ **Hours in Labor** __________

Outcome (☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps)

Birth Weight __________ **pounds** __________ **ounces**

Complications ____

Example: High blood pressure, diabetes, thyroid

Comments ____

Pregnancy 2: ☐ Male or ☐ Female

Delivery Date ________________________

Weeks Pregnant ____________ **Hours in Labor** __________

Outcome (☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps)

Birth Weight __________ **pounds** __________ **ounces**

Complications ____

Example: High blood pressure, diabetes, thyroid

Comments ____

Pregnancy 3: ☐ Male or ☐ Female

Delivery Date ________________________

Weeks Pregnant ____________ **Hours in Labor** __________

Outcome (☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps)

Birth Weight __________ **pounds** __________ **ounces**

Complications ____

Example: High blood pressure, diabetes, thyroid

Comments ____

Pregnancy 4: ☐ Male or ☐ Female

Delivery Date ________________________

Weeks Pregnant ____________ **Hours in Labor** __________

Outcome (☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps)

Birth Weight __________ **pounds** __________ **ounces**

Complications ____

Example: High blood pressure, diabetes, thyroid

Comments ____

Pregnancy 5: ☐ Male or ☐ Female

Delivery Date ________________________

Weeks Pregnant ____________ **Hours in Labor** __________

Outcome (☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps)

Birth Weight __________ **pounds** __________ **ounces**

Complications ____

Example: High blood pressure, diabetes, thyroid

Comments ____

Pregnancy 6: ☐ Male or ☐ Female

Delivery Date ________________________

Weeks Pregnant ____________ **Hours in Labor** __________

Outcome (☐ Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps)

Birth Weight __________ **pounds** __________ **ounces**

Complications ____

Example: High blood pressure, diabetes, thyroid

Comments ____

PATIENT AND FAMILY MEDICAL HISTORY

Pertains to Patient, her Parents, her Siblings and her Grandparents – Maternal Grandmother (MGM), Maternal Grandfather (MGF), Paternal Grandmother (PGM), & Paternal Grandfather (PGF) and Father of Baby (FOB) only.

SYSTEM	Condition	Self /Family Member	Year
Heart Disease			
High Blood Pressure			
Asthma /TB			
Thyroid Disease			
Diabetes			
Varicose Veins			
Blood Clots			
MRSA			
Kidney Disease			
Frequent Urinary Tract infections (> 3 per year)			
Epilepsy / Seizure Disorder			
Headaches /Migraines			
Abnormal PAP Smear			
COLPO, LEEP, CONE BOPSY			
Uterine Anomaly			
CANCER			
AUTOIMMUNE DISORDER HIV/LUPUS (SLE/DLE)			
Psychological Disorder			
Depression /Anxiety			
Preeclampsia /Toxemia			

GENETIC HISTORY:

Pertains to anyone in either the Patient or the Father of the Baby's families

SYSTEM	FAMILY MEMBER
SICLE CELL DISEASE OR TRAIT	
THALASSEMIA	
DOWN SYNDROME	
OPEN NEURAL TUBE DEFECT	
CYSTEC FIBROSIS	
TAY-SACHS DISEASE	
BIRTH DEFECTS	
MENTAL RETARDATION	
AUTISM	
HEMOPHILIA	
HUNTINGTON CHOREA	
STILLBIRTH	
MISCARRIAGE (3 OR MORE)	

Surgical History *i.e.: Oral Surgery, etc.*

Surgery ___________________________________ **Date**___________ **Complication**_____________________________

Surgery ___________________________________ **Date**___________ **Complication**_____________________________

Surgery ___________________________________ **Date**___________ **Complication**_____________________________

Development History

Patient returned from deployment in the last 90 days ☐ **YES** / ☐ **NO**

Spouse/Father of the baby deployed in the last 90 days ☐ **YES** / ☐ **NO**

Spouse/Father of the baby currently deployed ☐ **YES** / ☐ **NO**

Spouse/Father of the baby will deploy in the next 90 days ☐ **YES** / ☐ **NO**

Domestic Abuse Screening

1	Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?	
	☐ Yes	☐ No
2	Since being pregnant have you been hit, slapped, kicked, or otherwise physically hurt by anyone?	
	☐ Yes	☐ No
3	Within the last year, has anyone forced you to engage in sexual activities?	
	☐ Yes	☐ No

WOMACK Learning Needs Assessment: This is a MANDATORY WOMACK questionnaire that MUST BE COMPLETED FOR EACH PATIENT. Please mark your answers

1	What is your primary language? Select one							
	☐ English	☐ Spanish	☐ French	☐ German	☐ Other____________________			
2	What method(s) of learning do you prefer? Select al that apply							
	☐ Individual instruction	☐ Group Instruction	☐ Reading Material	☐ Video Presentation	☐ Demonstration			
3	Select any of the following that you consider personal barriers to learning							
	☐ Hearing	☐ Vision	☐ Speech	☐ Culture	☐ Religious	☐ Emotional	☐ None	☐ Other______
	_							
4	Do you have any religious/cultural beliefs that may impact your medical/health care?							
	☐ Yes	☐ No						
5	On a scale of 1-5, 1 being the least, how would you rate your desire to learn today?							
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			

Depression Screening

This questionnaire based the Edinburgh Postnatal Depression Scale, J.L. Cos, J.M. Holden, R. Sagovsky, (British Journal of Psychiatry). Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. The total score is calculated by adding together the scores for each of the ten items. Refer for a score of 12 or Greater.

Answer all questions. Please mark your answers

WITHIN THE LAST SEVEN (7) DAYS ….

1. I have been able to laugh and see the funny side of things

☐ 0-As much as I always could	☐ 1-Not quite as much now	☐ 2-Definitely not as much now	☐ 3-Not at all

2. I have looked forward with enjoyment to things

☐ 0-As much as I ever did	☐ 1-Rather less than I used	☐ 2-Definitely less that I used to	☐ 3-Hardly at all

3. I have blamed myself unnecessarily when things went wrong

☐ 3-Yes, most of the time	☐ 2-yes, some of the time	☐ 1-Not very often	☐ 0-No, never

4. I have been anxious or worried for no good reason

☐ 0-No, not at all	☐ 1-Hardly ever	☐ 2-Yes, sometimes	☐ 3-Yes, very often

5. I have felt scared and panicky for no good reason

☐ 3-Yes, quite a bit	☐ 2-Yes, sometimes	☐ 1-No, not as much	☐ 0-No, not at all

6. Things have been getting on top of me

☐ 3-yes, most of the time I haven't been able to cope at all	☐ 2-yes, sometimes I haven't been coping as well	☐ 1-No, most of the time I have coped well	☐ 0-No, I have been coping well

7. I have been so unhappy that I have had difficulty sleeping

☐ 3-Yes, most of the time	☐ 2-Yes, sometimes	☐ 1-Not very often	☐ 0-No, never

8. I have felt sad or miserable

☐ 3-yes, most of the time	☐ 2-Yes, quite often	☐ 1-Not very often	☐ 0-No, never

9. I have been so unhappy that I have been crying

☐ 3-yes, most of the time	☐ 2-Yes, quite often	☐ 1-Only occasionally	☐ 0-No, never

10. The thought of harming myself or other has occurred to me.

☐ 3-Yes, quite often	☐ 2-Sometimes	☐ 1-Hardly ever	☐ 0-Never

TOTAL SCORE (MIN VALUE 0, MAX VALUE 30):

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)* *(YYYYMMDD)*

Signature

I have read the above information

Date

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name —last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

MEDICAL RECORD -·CONSENT FORM

Human immunodeficiency Virus (HIV) Test

The Proponent Agency Is MCXC-DOM

I understand I am being asked to decide whether or not to have the HIV test. HIV causes Acquired Immunodeficiency

Syndrome (AIDS). This test shows if I have been infected with HIV.

By signing below, I understand that:

1. The HIV test detects antibodies to the Human Immunodeficiency Virus. HIV causes AIDS.
2. The HIV test is not 100% accurate. It can show a false positive when there is no infection. It can be a false negative when there really is an infection.
3. If I test positive, further testing is required.
4. If my test is truly positive, this does not mean that I have AIDS or will develop AIDS. It does mean that I could give HIV to another person.
5. The Department of Defense has directed that all Active Duty patients receive HIV testing. For civilians, HIV testing is encouraged but not required.
6. HIV test results have caused some individuals to be denied insurance coverage. I understand that my military coverage will not be changed.
7. If diagnosed with HIV, my treatment during pregnancy, labor and delivery, and treatment of my baby during the first 6 weeks of life can decrease the chance of my baby developing AIDS.
8. North Carolina law states:
   a. HIV testing is recommended for every pregnant woman during their first prenatal visit. Early testing will enable HIV-infected women and their infants to benefit from appropriate and timely interventions.
   b. IF AN INFANT IS DELIVERED TO A WOMAN WHOSE HIV STATUS IS UNKNOWN AT THE TIME OF DELIVERY, THE INFANT SHALL BE TESTED FOR HIV.

I have read and understand the information provided to me about HIV testing. My questions have been answered to my satisfaction. Please check one:

☐ **Yes, I want to have the test for HIV.**

☐ **No, I do not want to have the test for HIV.**

Patient:			
	(Signature)	(Print Name)	(Date)
Witness:			
	(Signature)	(Print Name)	(Date)

CENTERING PREGNANCY SCREENING TOOL

Centering pregnancy is a dynamic group prenatal care program available in the WAMC OB/GYN Clinic. Centering is an alternative to traditional prenatal care. Care is provided in a group setting without waiting for appointments, approximately 12 women with similar due dates actively participate in their care and can share their experiences while gaining knowledge regarding pregnancy, childbirth, and parenting. Individual provider visits and group educational sessions are provided in 2-hour blocks of time so that you can get on with other things busy moms must accomplish. Groups usually start around 16 weeks and continue until delivery. These questions can assist us in determining if this program may be beneficial for you, once this information is reviewed a nurse from our clinic may contact you to discuss this exciting opportunity.

	YES	**NO**
1. Are you planning on delivering at Womack Army Medical Center?		
2. Are you ok with not bringing children to your appointments?		
3. Can you devote two hours to your appointments if they are set times?		
4. Would you be willing to participate in group discussions with other pregnant women (due in the same month) regarding pregnancy and postpartum topics?		
5. Is this pregnancy considered to be high-risk?		

Name:		Phone Number:	
Due Date:		Sponsor last 4:	

WAMC OB Smoking Screening Version: 2

Please screen for smoking at first visit. Use comment block for additional information

1.	**I smoke regularly now- about the same amount as before finding out I was pregnant.**	
	☐ **Yes**	☐ **No**
2.	**I smoke regularly now, but I've cut down since finding out I was pregnant.**	
	☐ **Yes**	☐ **No**
3.	**I smoke occasionally.**	
	☐ **Yes**	☐ **No**
4.	**I smoked the first few months that I was pregnant, but I am no longer smoking.**	
	☐ **Yes**	☐ **No**
5.	**I have quit smoking since finding out I was pregnant.**	
	☐ **Yes**	☐ **No**
6.	**I wasn't smoking around the time I was pregnant, and I don't currently smoke.**	
	☐ **Yes**	☐ **No**
7.	**I have never smoked.**	
	☐ **Yes**	☐ **No**
Comments		

WAMC OB/GYN Zika Questionnaire

Version: 9

Please screen for Zika virus exposure at every visit

Use commend box for additional information

1.	Have you or your sexual partner traveled to any Zika affected area (Mexico, Caribbean (including Puerto Rico and US Virgin Island), Central America, South America, and pacific Islands) within the past 8 Weeks or planning to in the future?		
	☐ **Yes (Notify provider)**	☐ **No**	
2.	Did you or your male sexual partner experience any illness during the Trip		
	☐ **Yes**	☐ **No**	☐ **N/A**
3.	If you or your male partner has experienced any illness, please select all Symptoms that apply from the list below and state onset date (use commend box for date)		
	☐ **Fever**	☐ **Joint pain (Arthralgia)**	☐ **Rash**
	☐ **Red eye (Non-purulent Conjunctivitis)**	☐ **Other (specify): Use commend box**	
Comments			

Add New Subscriber

Name			
Email			
Zip			
Baby Due Date		**Your Gender**	
Your Date of Birth		**Relation to Baby**	
How did you hear about our service?			