Obstetrical Intake Appointment

Name:	**Date of Birth:**
Occupation:	Race:
Marital Status (circle): Single Married Long-term relationship Living Together	

Father of the Baby Information or Partner information for Donor pregnancies:

Name:	Date of Birth:
Occupation:	Race:
Is the Father of the baby involved?	
Does the Father of the baby have children from previous/other relationship? No Yes	
Significant Medical history for Father of the baby:	

Menstrual History:

Date of the **first day** of your Last Menstrual Period:	**Cycle interval (ex: Every 28 days):**
Certainty of date: Sure Unsure	
Was this a spontaneous pregnancy or result of infertility treatment: Spontaneous Treatment	

Symptoms and Exposures Since Last Menstrual Period:

	No	Yes	Details
Vaginal Discharge or bleeding:			
Headaches:			
Nausea:			
Vomiting:			
Pain with urination:			
Viral illness/Rash/Fever/other:			

Medications taken since Last Menstrual Period: (Please include Medications stopped with positive Pregnancy Test)

Medication	Still Taking? Y N (If no, date of last dosing)

EXPOSURES (Have you been exposed to any of the following)

	No	Yes	Details
X-rays (within the last month) or harmful chemicals			
Contagious Diseases (within the last month)			
Do you or your partner have Herpes, HIV or other			
Other possible exposures			

Smoking History (Please Check which applies):

	Never	
	Quit	# Packs per day:______ # years smoked:_______ Quit Date:________
	Current Smoker	# Packs per day:______ # years smoked:__________

Alcohol Usage (Please check which applies):

	None
	Yes # of drinks per week prior to pregnancy:_______ or other:

Illicit Drug Usage (Please check which applies):

	Never
	History of but none within the last 6 months Date and type of last usage:
	Current (within last 6 months) Type/Amount: