

Obstetrics New Patient Form

PHYSICIANS EAST, P.A.

Greenville Women's Care

2251 Stantonsburg Road, Greenville, NC 27834

Date _____ DOB _____ Occupation _____

Name _____ Marital status _____

FOB _____ Age _____

Total Pregnancies	Full term	Preterm	Induced Ab	Spontaneous Ab	Ectopics	Multiples	Living

PROBLEMS

- _____
- _____
- _____
- _____
- _____

LMP _____ definite unsure

Ultrasound _____

PAST PREGNANCY HISTORY

Date	Gestational age	Birth wt	Sex	Type of delivery	Anesthesia	Place	Complications

PREVIOUS OBSTETRIC PROBLEMS

- History of GBS
- History of preterm labor
- History of preeclampsia
- History of gestational diabetes

LABS (nurse to fill out)

Blood Type	
Rh Type	
Antibody screen	
Hct	
pap	

Rubella	
VDRL	
Urine	
HBsAg	
HIV	

PPD	
Chlamydia	
Gonorrhea	
CF screen	
Hgb electrophoresis	

Tobacco use _____

Alcohol use _____

Illicit drug use _____

MEDICATIONS TAKEN SINCE BECOMING PREGNANT

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL HISTORY

- | | | | | | |
|------------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| | Self | Family | | Self | Family |
| 1. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 12. Infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | 13. STDs | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | 14. Abnormal pap smears | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Autoimmune disorder | <input type="checkbox"/> | <input type="checkbox"/> | 15. Complications with anesthesia | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | 16. Hospitalizations | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Neurological disease | <input type="checkbox"/> | <input type="checkbox"/> | 17. Operations | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Psychiatric disease | <input type="checkbox"/> | <input type="checkbox"/> | 18. Gyn surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Depression | <input type="checkbox"/> | <input type="checkbox"/> | 19. Breast disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Hepatitis / liver disease | <input type="checkbox"/> | <input type="checkbox"/> | 20. Allergic reactions | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | 21. Lung disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Domestic violence | <input type="checkbox"/> | <input type="checkbox"/> | 22. Blood transfusions | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 23. Blood clots | <input type="checkbox"/> | <input type="checkbox"/> |

GENETIC SCREENING

- | | | | | | |
|-----------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| | Self | Family | | Self | Family |
| 1. Thalasemia | <input type="checkbox"/> | <input type="checkbox"/> | 8. Recurrent pregnancy loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Neural tube defects | <input type="checkbox"/> | <input type="checkbox"/> | 9. Metabolic disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> | 10. Downs syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Tay Sachs | <input type="checkbox"/> | <input type="checkbox"/> | 11. Mental Retardation | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | 12. Huningtons Chorea | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> | 13. Cystic Fibrosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Muscular Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Physicians East, P.A.

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If there have been no changes since your last visit, please fill in only the medications & review of system sections.

DATE: _____ DOB: _____ OCCUPATION _____

NAME: _____ AGE: _____ MEDICAL RECORD #: _____

Number of Pregnancies: _____ Number of Term Deliveries: _____ Number of Preterm Deliveries: _____

Number of Miscarriages or Abortions: _____ Date of Last Menstrual Period: _____

Preg #	Date	Place	Delivery Type	Duration of Labor	Complications	Birth Weight	Child's Sex & Name

Please take a moment to fill this out so that we may update your medical history. Your confidential answers will help us to take better care of you.

Why are you coming to see us today?

What medical problems do you have?

What operations have you had?

<u>Operation</u>	<u>Approx. Year</u>	<u>Operation</u>	<u>Approx. Year</u>

What medications do you take:

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>

What medications are you allergic to: _____

REVIEW OF SYSTEMS:

- Do you have difficulty with depression? Yes No
- Are you now in a relationship with a person who threatens or physically abuses you? Yes No
- Do you have any problems or concerns about sexual issues? Yes No
- Do you have fainting spells or seizures? Yes No

Do you struggle with being short of breath? Yes No
 Do you have chest pain or an unusual heart rate? Yes No
 Do you have frequent nausea or vomiting? Yes No
 Do you have frequent diarrhea or ever have bloody stools? Yes No
 Have you had a recent change in abdominal girth? Yes No
 Do you have a problem with leaking urine? Yes No
 Have you had a recent change in how frequently you must urinate, or does it hurt to urinate? Yes No
 Have you had a significant change in weight or fatigue? Yes No
 Do you have a problem with painful, swollen joints? Yes No
 Have you had unusual fevers or chills? Yes No
 Do you examine your own breasts? Yes No
 Have you noted any breast lumps, skin changes or nipple discharge? Yes No

SOCIAL HISTORY:

Do you smoke? Yes No
 Do you drink alcohol? Yes No Frequency of consumption _____
 Are you planning to get pregnant? Yes No
 What, if anything, do you use to keep from getting pregnant? _____

FAMILY HISTORY:

Have any close relatives had (please describe who):

Breast Cancer	Yes	No	_____
Ovarian Cancer	Yes	No	_____
Other Cancer	Yes	No	_____
Heart Disease	Yes	No	_____
Diabetes	Yes	No	_____
Other medical problems	Yes	No	_____

Breast Cancer Risk Screen:

Race: White Black Asian Other: _____
 Your age at first menstrual period? _____ Age at first live birth? _____
 Number of sisters/daughters/or mother with breast cancer? _____
 Number of previous breast biopsies? _____
 Did biopsy have atypical hyperplasia? Yes No Unknown

HEALTH MAINTENANCE:

When was your last Pap smear? _____
 Have you ever had an abnormal Pap? _____ When? _____
 When was your last mammogram? _____
 When was your cholesterol last checked? _____
 When was the last time you had a flexible sigmoidoscopy, if ever? _____

Do you exercise regularly? Yes No
 Do you take any vitamins? Yes No
 Do you take calcium? Yes No
 Have you had a Tetanus booster? Yes No

SIX WEEKS CHECKUP	
Sex	Name
Type Delivery	
Date Delivery	
Type Feeding	