OBRIA MEDICAL CLINICS

Intake Form
Prenatal Care

MRN:
(Office Use Only)

Name: ________________________________ Date of Birth: ____________________

Pregnancy History

Total Pregnancies #: __________ Children #: __________ Ages: ____________________

Abortions: Spontaneous (Miscarriage) #________ Induced (Abortion) #________ Ectopic #_________

Any complications during pregnancy, labor, delivery, or post-partum period?

○ Episiotomy ○ C-Section ○ Post-partum bleeding ○ Depression ○ Vaginal lacerations
Forceps ○ Preeclampsia ○ Gestational Diabetes

Other: ____

Gynecological History

First Day of your last menstrual period: ____________________
How old were you when your menses started? ____________________
How many days between your periods? ____________________
How many days of menstrual flow? ____________________
Are you still having menstrual periods? □ Yes □ No
If so, periods are: □ Light □ Moderate □ Heavy □ Bleed through protection

Medical Questions

Do you have any pain with your periods?	□ Yes	□ No
Are your periods regular?	□ Yes	□ No
Do you ever have more than 35 days in-between periods?	□ Yes	□ No
Do you get less than 6 periods a year?	□ Yes	□ No
Do you have bleeding in between periods?	□ Yes	□ No
Do you pass any clots in menstrual flow?	□ Yes	□ No
Do you have bleeding after intercourse?	□ Yes	□ No
Do you have a history of anemia?	□ Yes	□ No
Have you had a blood transfusion?	□ Yes	□ No
Have you ever been diagnosed with fibroids?	□ Yes	□ No
Have you ever been diagnosed with polyps inside the uterus?	□ Yes	□ No
Do you suffer from pre-menstrual syndrome (PMS)?	□ Yes	□ No
Do you have a history of endometriosis?	□ Yes	□ No
Do you have a history of pelvic pain?	□ Yes	□ No
Are you sexually active now?	□ Yes	□ No
Do you have any questions about sex you would like to ask?	□ Yes	□ No

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Sexual Activity

Number of current partners? □ One □ Multiple
Partner(s) are: □ Male □ Female □ Both

What is your present method of birth control?
□ None □ Pill □ NuvaRing □ Natural Family Planning □ Implant □ Condom □ Vasectomy
□ Mirena IUD □ Copper T IUD □ Depo-Provera Injections □ Other: ______________________

Date of Last Pap smear: _______________ Result: ____________________________________
Have you ever had an abnormal Pap smear or Colposcopy? □ Yes □ No
Have you had any treatment to your cervix? □ Yes □ No
If yes, what treatment? ____
Have you ever had a sexually transmitted disease? □ Yes □ No
If yes, what disease(s)? ____
Do you have frequent yeast infections? □ Yes □ No
Do you have recurrent vaginal infections? □ Yes □ No

Past Operations/Hospitalizations

Please indicate the year and reason for operation/hospitalization

____
____
____
____
____

Medical History

Please list your medical problems (for example, high blood pressure, diabetes, etc.):

____
____
____

Current Medications

(Please list all medicine, over-the-counter, and herbal supplements taken within the last 3 months)

Medication Name	Dose	Frequency	Start Date	End Date	Prescribed By:	Initials of Reviewer:

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Allergies and Reactions

____

____

Social History

Current and Past Alcohol Intake (drinks per week): ______________________
Do you use recreational drugs? □ Yes □ No
Have you ever received treatment for substance abuse? □ Yes □ No
If you smoke: Number of cigarettes per day: ______________________
Past Cigarette Use (years): ______________________
Exercise (type, frequency, duration): ______________________
Describe your diet: ______________________
Are you losing weight? □ Yes □ No

Personal Safety

Do you feel safe at home? □ Yes □ No
Has anyone, including your partner, ever forced you to have sex? □ Yes □ No
Have you ever been sexually, physically or emotionally abused? □ Yes □ No

Health Maintenance and Screening (If you've had and know the results)

Date and result of last mammogram: Date: ____________ Result: ____________
Have you ever had an abnormal mammogram, breast ultrasound or breast biopsy? □ Yes □ No
Do you do monthly self-breast exams? □ Yes □ No
Date and result of last HIV test: Date: ____________ Result: ____________
Date of last HPV vaccine: Date: ____________ Result: ____________
If you had, did you receive all three shots? □ Yes □ No
Do you have another primary care provider who is taking care of you for regular check-ups?
□ Yes □ No

Family History

Person & relationship to you (e.g. mother, maternal grandfather, etc.)

□ Breast Cancer ______________________
□ Ovarian Cancer ______________________
□ Uterine Cancer ______________________
□ Colon Cancer ______________________
□ Diabetes ______________________
□ High Cholesterol ______________________
□ High Blood Pressure ______________________
□ Heart Disease ______________________
□ Osteoporosis ______________________
□ Premature Menopause ______________________
□ Alzheimer's Disease ______________________
□ Other: ______________________

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Review of Systems

Are you experiencing any of the following?

Constitutional:
Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Unintentional Weight Loss ☐ Yes ☐ No
Unintentional Weight Gain ☐ Yes ☐ No

Ears, Nose, Mouth and Throat:
Frequent Nosebleeds ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Sore/Ulcer in mouth ☐ Yes ☐ No

Cardiovascular:
Chest Pain ☐ Yes ☐ No
Calf Pain or Shortness of Breath with Walking ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Swelling in the Feet and/or Ankles ☐ Yes ☐ No
Rapid Heart Rate ☐ Yes ☐ No

Respiratory:
Exposure to Tuberculosis ☐ Yes ☐ No
Sudden Onset of Painful and Difficult Breathing ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No

Gastrointestinal:
Acid Reflux/Heartburn ☐ Yes ☐ No
Bloating ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Nausea/Vomiting ☐ Yes ☐ No
Change in Bowel Movements ☐ Yes ☐ No

Genitourinary:
Urinary frequency ☐ Yes ☐ No
Burning with urination ☐ Yes ☐ No
Red/pink-tinged urine ☐ Yes ☐ No
Sensation of incomplete bladder emptying ☐ Yes ☐ No
Frequent bladder infections ☐ Yes ☐ No
History of renal stones ☐ Yes ☐ No

Musculoskeletal:
Joint Pain/Back Pain ☐ Yes ☐ No
Muscle Weakness ☐ Yes ☐ No
Joint Stiffness ☐ Yes ☐ No

Skin:
Acne ☐ Yes ☐ No
Atypical Moles ☐ Yes ☐ No

Breast Tenderness	□ Yes	□ No
Breast Skin Changes/Masses	□ Yes	□ No
Nipple Discharge	□ Yes	□ No
Neurological:		
Headaches	□ Yes	□ No
Seizures	□ Yes	□ No
Tremors	□ Yes	□ No
Trouble Walking	□ Yes	□ No
Hematological:		
Easy Bruising	□ Yes	□ No
Cuts that do not stop bleeding	□ Yes	□ No
Enlarged/Swollen Lymph Nodes	□ Yes	□ No
Endocrine:		
Heat/Cold Intolerance	□ Yes	□ No
Excessive Hair Growth	□ Yes	□ No
Abnormal Thirst	□ Yes	□ No
Psychiatric:		
Anxiety	□ Yes	□ No
Crying Spells	□ Yes	□ No
Depression/Prolonged Sadness	□ Yes	□ No
Feeling Stressed	□ Yes	□ No
Loss of Interest in Pleasurable Activities	□ Yes	□ No
Poor Concentration	□ Yes	□ No
Sleep Disturbances	□ Yes	□ No
Suicidal Thoughts	□ Yes	□ No

______________________________ ______________________
Provider Signature Date Reviewed