Arbor ObGyn Pregnancy Intake Worksheet, for: _____

Welcome! Please complete this worksheet, which enables us to transcribe your obstetric information into our record system. Bring it with you to your first appointment.

Pre-pregnancy weight: _____ lbs.
Father of Baby: _____,
phone: (_____) _____
relationship: _____.
Current Pediatric Office: _____

Previous Pregnancies
Including this pregnancy, the total number of:
_____ All pregnancies
_____ Full-Term (37+ weeks)
_____ Pre-Term (20-36 weeks)
_____ Early losses, miscarriages or abortions
_____ Ectopic tubal pregnancies
_____ Twin pregnancies
_____ Living children that you birthed
_____ Other children that you have (adopt, step-)

1st day of your Last Menstrual Period: ____/ ____ / ____ ..... definite - or - approximate?
Menses Monthly? Yes – No.
Menses frequency, new every _____ days.
Date that you think you conceived? ____/ ____ / ____
On Birth Control when you conceived? Yes - No
Date Home Preg Test Positive?: ____/ ____ / ____
or, IVF Embryo Transfer Date: ____/ ____ / ____

✳ ***Previous Pregnancy Data.*** *Complete the boxes **ONLY** if <u>today's</u> pregnancy is your first with Arbor.*

> Date: ____/ ____ / ____
> Fullterm, Preterm, Miscarriage, Ectopic, Other?
> Male or Female.
> Weight: _____ #, _____ oz.
> Forceps, Vacuum, Normal Vaginal, VBAC, C-Section, Ectopic, Abortion, Miscarriage?
> Gestational Age: ____ wks, ___ days.
> Anesthesia: General, Epidural, Spinal, None?
> Preterm labor hospital admission? Yes, No.
> Delivery Location: _____
> Baby's Name: _____
> Hypertension? _____ . Diabetes? _____
> Things we should know about:
_____
_____
_____

> Date: ____/ ____ / ____
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> Male or Female.
> Weight: _____ #, _____ oz.
> Forceps, Vacuum, Normal Vaginal, VBAC, C-Section, Ectopic, Abortion, Miscarriage?
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> Baby's Name: _____
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> Things we should know about:
_____
_____
_____

Please complete the screening questions. This relates to the pregnant woman, father of the baby, and/or a previous baby. Add Comments as needed.

Condition			Comments
Patient's age will be 35+ years on Due Date	Y	No	
Thalassemia (blood disorder)	Y	No	
Neural Tube Defect in you or baby (Spina Bifida)	Y	No	
Congenital Heart Defect	Y	No	
Down Syndrome	Y	No	
Tay-Sachs (Jewish hereditary Disease)	Y	No	
Canavan (Jewish hereditary Disease)	Y	No	
Sickle Cell Disease or Trait	Y	No	
Hemophilia or other Blood Disorders	Y	No	
Muscular Dystrophy, M.S.	Y	No	
Cystic Fibrosis	Y	No	
Huntington's Chorea	Y	No	
Intellectual Disability, Autism	Y	No	
Fragile X	Y	No	
Other Inherited Genetic or Chromosome Disorder	Y	No	
Maternal Metabolic Disorder – Like Diabetes or PKU	Y	No	
Have you or partner had a baby with a birth defect?	Y	No	
Recurrent Pregnancy Loss (2x+) or Stillbirth	Y	No	
Medications or Supplements?	Y	No	*List below, please*
Alcohol, Illicit / Recreational Drugs	Y	No	*List below, please*
Other Genetic History?	Y	No	
Live with or Exposed to Tuberculosis	Y	No	
Patient or Partner has Genital Herpes (HSV)	Y	No	
Rash or Viral Illness since last menstrual period	Y	No	
Sexually Transmitted disease history (Gonorrhea, Chlamydia, HPV, Syphilis, Trichomonas, Others)	Y	No	
Other Infections	Y	No	
Hepatitis B or Hepatitis C	Y	No	
Previous baby INFECTED with Group B Strep	Y	No	

As of Today: Smoke/Vape? _____. Alcohol Use: ____
In the past year: Marijuana/CBD? ____. Other Illegal Drugs: _____

Medication or Supplement	Dosage	Times per day	Prescriber