

MRN: _____

New Obstetrics Patient Intake Form

Answer all questions as they apply to you. This form will be added to your medical record.

Please select your physician:

- Dr. Robin Kalish**
- Dr. Inna Landres**
- Dr. John Ilagan**
- Dr. Shai Pri-Paz**
- Dr. Vander Haar**

Legal Last Name: _____	Legal First Name: _____
Who referred you? _____	Primary Care Provider: _____
Age: _____	Reason for visit: _____

Menstrual History

Date of last menstrual period: _____ Age (yrs) at 1st period: _____ Age at Menopause: _____
 My period usually occurs every _____ days and lasts for _____ days.

Please circle No or Yes.

Heavy Periods: No Yes Painful Periods: No Yes Irregular Bleeding: No Yes PMS (bloating, moody): No Yes

Genetic History

Ethnic Background: _____ Partner's Age & Ethnic Background: _____

Has anyone in your family or your partner's family had any of the following? If so, please include which family member(s).

- | | |
|--------------------------------|------------------------------|
| Autism _____ | Mental Retardation _____ |
| Birth Defect _____ | Muscular Dystrophy _____ |
| Congenital Heart Disease _____ | Open Spine (Bifida) _____ |
| Cystic Fibrosis _____ | Sickle Cell Anemia _____ |
| Down's syndrome _____ | Thalassemia _____ |
| Hemophilia _____ | Unexplained Fetal Loss _____ |
| Huntington's disease _____ | Other _____ |

Gynecologic History

Last Pap smear: _____ Abnormal Pap Smears: No ___ Yes ___ (Year & Treatment given) _____

Last Mammogram: _____ Abnormal Mammograms: No ___ Yes ___ (Year & Treatment given) _____

Have you ever had any of the following infections? (Please check all that apply).

Gonorrhea ___ Chlamydia ___ Herpes ___ Trichomonas ___ Genital Warts/HPV ___ Syphilis ___ None ___

If so, when and how was it treated? _____

Have you had any of the following conditions? (Please check all that apply).

Uterine Fibroids ___ Infertility ___ Ovarian Cysts ___ Breast disease/biopsy ___ Endometriosis ___ None ___

If so, please detail year and how it was treated? _____

Contraception/Pregnancy History

Sexually active: No Yes Medical issues pertaining to sexual activity: _____

Current method of preventing pregnancy: _____

Total number of: pregnancies ___ Vaginal deliveries ___ C-Section ___ Miscarriages ___ Abortions ___ Ectopic ___

Pregnancy Complications: _____

Would you accept a blood transfusion in a life threatening situation? NO ___ YES ___

Pregnancy History

Date	Delivery Type	Birth Weight	Gender/Name	Complication

MRN: _____

*** ALLERGIES: No ___ Yes ___ Please list allergies: _____

Medications: (List names and dosages; include vitamins, herbs, and other supplements):

Medication	Dosage	How Often	Medication	Dosage	How Often

Past and Current Medical History (Please include year if diagnosis and treatment were given).

_____ Anemia (Blood Transfusion?)	_____ Hemorrhoids	_____ Neurologic Disorder
_____ Anesthesia Complications	_____ Hiatal Hernia	_____ Psychiatric Disorder
_____ Breast disease	_____ Kidney Stones	_____ Seizure Disorder/Epilepsy
_____ Congenital Heart Problem	_____ Lung Disease/Asthma	_____ Sickle Cell/Carrier
_____ Diabetes	_____ Lupus	_____ TB/ Positive PPD
_____ Gastrointestinal/Gallstones	_____ Migraine Headaches	_____ Thrombotic Disorder (Blood Clots)

Surgical History (Briefly include your surgical history).

Family History

Mother: Living: _____ Deceased (Cause): _____ Father: Living _____ Deceased (Cause): _____

Siblings Number Living: _____ Number deceased: _____ Cause: _____

Detail below if anyone in your immediate family had the diagnosis: (Please indicate Mother, Father, Sibling, Grandparents and which side).

_____ Bleeding Disorder	_____ Cancer-Other	_____ High Blood Pressure	_____ Neurological Disease
_____ Blood Clots	_____ Diabetes	_____ High Cholesterol	_____ Psychiatric Disease
_____ Cancer: Breast/GYN	_____ Heart Disease	_____ Multiple Pregnancy	_____ Thyroid Disease
Other _____			

Social History

Occupation: _____ Marital Status: _____ Do you smoke? _____ If so, how many packs a day? _____

Do you drink alcohol? No Yes If so, how many drinks/week? _____ Do you take drugs? _____ If so, which ones? _____

Review of Systems: Are you experiencing any of the following symptoms? Please indicate all that apply or NO if they do not.

Constitutional	No	_____ Fatigue	_____ Weight Loss	_____ Weight Gain	_____ Fever
Eye Problems	No	_____ Vision Changes	_____ Glasses/Contacts		
Ear, Nose, Throat	No	_____ Headache	_____ Sinusitis	_____ Ringing in Ears	_____ Nose Bleed
Cardiovascular	No	_____ Shortness of Breathe	_____ Chest Pain	_____ Edema	_____ Palpitations
Respiratory	No	_____ Wheezing	_____ Coughing Blood	_____ Cough	
Gastrointestinal	No	_____ Nausea/vomiting	_____ Constipation	_____ Diarrhea	_____ Bloody Stool
Genitourinary	No	_____ Bloody Urine	_____ Painful Urination	_____ Urgency	_____ Frequency
Musculoskeletal	No	_____ Muscle Weakness	_____ Muscle Pain		
Skin/Breast	No	_____ Breast Pain	_____ Nipple Discharge	_____ Breast Mass	_____ Skin Rash
Neurological	No	_____ Fainting	_____ Seizures	_____ Numbness	_____ Trouble Walking
Psychiatric	No	_____ Depression	_____ Anxiety		
Endocrine	No	_____ Dry skin	_____ Abnormal Thirst	_____ Hot Flashes	
Blood/Lymph	No	_____ Easy Bruising	_____ Abnormal Bleeding	_____ Swollen Glands	

Other _____

Reviewed By: _____, MD on _____

Date