Obstetrics New Patient Form

PHYSICIANS EAST, P.A.

Greenville Women's Clinic
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

1. ____
2. ____
3. ____
4. ____
5. ____

LMP ________________ ☐ definite ☐ unsure

Ultrasound________________

PAST PREGNANCY HISTORY

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

PREVIOUS OBSTETRIC PROBLEMS

1. History of GBS ☐
2. History of preterm labor ☐
3. History of preeclampsia ☐
4. 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
1. Diabetes	☐	☐
2. Hypertension	☐	☐
3. Heart Disease	☐	☐
4. Autoimmune disorder	☐	☐
5. Kidney disease	☐	☐
6. Neurological disease	☐	☐
7. Psychiatric disease	☐	☐
8. Depression	☐	☐
9. Hepatitis / liver disease	☐	☐
10. Thyroid disease	☐	☐
11. Domestic violence	☐	☐

	Self	Family
12. Infertility	☐	☐
13. STDs	☐	☐
14. Abnormal pap smears	☐	☐
15. Complications with anesthesia	☐	☐
16. Hospitalizations	☐	☐
17. Operations	☐	☐
18. Gyn surgery	☐	☐
19. Breast disease	☐	☐
20. Allergic reactions	☐	☐
21. Lung disease	☐	☐
22. Blood transfusions	☐	☐
23. Blood clots	☐	☐

GENETIC SCREENING

	Self	Family
1. Thalasemia	☐	☐
2. Neural tube defects	☐	☐
3. Congenital heart disease	☐	☐
4. Tay Sachs	☐	☐
5. Sickle Cell Disease	☐	☐
6. Bleeding disorder	☐	☐
7. Muscular Dystrophy	☐	☐

	Self	Family
8. Recurrent pregnancy loss	☐	☐
9. Metabolic disorders	☐	☐
10. Downs syndrome	☐	☐
11. Mental Retardation	☐	☐
12. Huningtons Chorea	☐	☐
13. Cystic Fibrosis	☐	☐

Physicians East, P.A.

Greenville Women's Clinic
2251 Stantonsburg Road, Greenville, NC 27834

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?

Operation	Approx. Year	Operation	Approx. Year

What medications do you take:

Name	Dose	Frequency	Name	Dose	Frequency

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

GWC 1

OVER ⟶

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