ROSENBERG Maternal–Fetal Medicine

1229 Broadway
Suite 201
Hewlett, NY 11557

INTAKE FORM

Date completing the form: ___________________ Referred By: ____

Patient Name: ____

Address: ____

City: ________________________________ State: ____________________ Zip: __________________

Contact # Cell: __________________ Home: ____________________ Email: _________________________________

Age: ______ DOB ____________ Height: ____Feet_____Inches Current Weight: ______ pounds

Occupation: ____ Work Phone: _________________________________

Name of Spouse/Partner: __________________________ DOB ___________ Occupation: _____________________

Why were you referred to our office? ____

Last Menstrual Period (first day): ______________

IF YOU ARE NOT PREGNANT PLEASE SKIP TO THE NEXT PAGE

Who is your primary obstetrician/obstetrical group/midwife? ____________________________________

Where do you plan to deliver your baby? ____________________________________

(**PLEASE NOTE:** our office policy is that you cannot be seen during pregnancy unless you identify above the obstetrician/midwife who is responsible for your routine obstetrical care and delivery of the baby. Dr. Rosenberg does not do routine obstetrics and does not deliver babies.)

What is the due date assigned by your obstetrician/midwife? ______________

Are you carrying more than one baby? YES ___ NO ___. If yes, ___Twins ___Triplets (check one)

Pregnancy conceived via infertility treatment? YES ___ NO ___. If yes, ___IVF ___IUI (check one)

For IVF: Date of embryo transfer: ___________ ___3 day ___5-day transfer (check one)

Number of embryos transferred: _______ Age of donor egg _______ (if applicable)

Have you had any of the following tests performed?

[ ] Ultrascreen/First trimester screen [ ] Sequential screen [ ] NIPS (non-invasive prenatal screen)

Were you told that they were ___normal ___ abnormal ___don't know (check one)

Please list any pregnancy complications so far: ____
(bleeding, cramping, abnormal ultrasound findings, cervical shortening etc.)

When is your next appointment with your obstetrician/midwife? ___________

OBSTETRICAL HISTORY - List all of your deliveries:

Month/Year	# weeks at delivery	Birth Weight	Sex	Vaginal or cesarean If C/S, why?	Pregnancy Complications (please provide details)	Problems with baby (please provide details)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

List all miscarriages, abortions, ectopic pregnancies:

Month/Year	# weeks	Miscarriage (M) Abortion (A) Ectopic (E)	D&C (Y/N)	Was an ultrasound done? (Y/N)	Was there ever a heartbeat? (Y/N)	Was there only an empty sac? (Y/N)	Any genetic testing done on the pregnancy? If yes, please provide details
1.							
2.							
3.							
4.							
5.							
6.							
7.							

GYNECOLOGICAL HISTORY

Have you ever been diagnosed with?

Fibroids YES ___ NO ___

Ovarian Cysts YES ___ NO ___

Gynecologic Infections YES ___ NO ___

Please provide any details: ____

MEDICAL AND SURGICAL HISTORY

Have you ever been diagnosed with any of the following? (CHECK ALL THAT APPLY)

[ ] Diabetes
[ ] Hypertension
[ ] Seizure disorder/epilepsy
[ ] Anemia
[ ] Lupus
[ ] Asthma
[ ] Heart Condition
[ ] Thyroid disorder
[ ] Liver Disorder
[ ] Kidney Disease
[ ] Respiratory disorder
[ ] Blood clots (DVT)
[ ] Pulmonary embolism
[ ] Clotting disorder
[ ] Bleeding disorder

[ ] Stomach or digestive problems	[ ] Depression/ Anxiety/other psychiatric problems	[ ] Cancer	[ ] OTHER

Please provide details regarding any of the above checked items: ______________________________________

____

Previous Surgical History:

List any prior surgical procedures:

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

If you had surgery on your uterus, cervix, ovaries, please provide details:

____

Have you ever received a blood transfusion? YES ___ NO ___ Details: __________________________

CURRENT MEDICATIONS (names and dosages):

____

ALLERGIES: YES ___ NO ___ Please provide details: ____

FAMILY/GENETIC HISTORY:

Are there medical disorders that run in your family that we should be aware of? YES ___ NO ___

If yes, please provide details: ____

Is there any known history in your family or your spouse's family of any birth defects, genetic disorders, chromosomal abnormalities or inherited disorders? YES ___ NO ___

If yes, please provide details: ____

What is your ethnicity? ___________________ What is your spouse/partner's ethnicity? _______________________

Would you want to be referred for genetic counseling? YES ___ NO ___

SOCIAL HISTORY:

Do you smoke cigarettes? YES ___ NO ___. If yes, please provide details__________________________

Do you drink alcohol regularly? YES ___ NO ___. If yes, please provide details__________________________

Do you use recreational drugs? YES ___ NO ___. If yes, please provide details__________________________

I attest that the above information is correct to the best of my knowledge.
I agree with the office policy outlined on page 1 of 3 with regard to being seen in this office during pregnancy.

________________________________ ___________________________________

Patient name (print) Signature