

INTAKE FORM

Date Completing 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 (circle one)

Pregnancy conceived via infertility treatment? YES ___ NO ___. If yes, IVF / IUI (circle one)

For IVF: Date of embryo transfer: ___/___/___ 3 day / 5-day transfer (circle 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 (circle 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? ___/___/___

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

**PLEASE RETURN THE
COMPLETED INTAKE FORM
TO:**

RECEPTION@ROSENBERGMFM.COM

**OR YOU CAN FAX IT TO
516-501-9850.**