Black Hills Obstetrics and Gynecology

New OB Patient form

Today's Date_____ **required field*

Name* _____ Date of Birth: {DD/MM/YYYY} **required field*

Address* _____

Phone Number _____ ☐ cell ☐ home Ok to leave msg ☐ Yes ☐ No

Alternate Phone Number _____ ☐ cell ☐ home Ok to leave msg ☐ Yes ☐ No

Insurance Company *_____

If Medicaid, who is listed as your managing primary care provider? _____

OBSTETRICIAN: *please check who you are currently scheduled with for your pregnancy* *

☐ Shana Bernhard, MD ☐ Katherine Degen, MD ☐ Marvin Buehner, MD

☐ Michelle Krohn, DO ☐ Anthony Diehl, MD

If you have transferred your care to BH/OB GYN, what was the date of your first prenatal visit for this pregnancy? MM/YYYY Reason for transfer:_____

Language: ☐English ☐Spanish ☐Other:_____

Special needs: ☐ cognitive ☐ hearing ☐ language ☐ vision ☐ physical

Current Medications: ☐ Prenatal Vitamin ☐ None

Please list current medications: _____

Medication Allergies: _____

_____

Who may we contact in the case of an emergency? * _____

Relation to you *_____Phone Number:* _____

Relationship Status: ☐ Married ☐ Single ☐ Engaged ☐ Divorced ☐ Separated

Father of the Baby's name:*_____

Is the Father of the baby planning to be involved with your pregnancy? ☐ Yes ☐ No

Is he supportive of the pregnancy? ☐ Yes ☐ No

Do you have any safety concerns for you or your baby? ☐ Yes ☐ No

If Yes, please explain: _____

Current or most recent occupation: _____

Check all that apply: ☐ Full Time ☐ Part Time ☐ Currently Unemployed ☐ Homemaker ☐Student

What have you used in the past for contraception? Check all that apply: *

☐ Condoms ☐ Oral Contraceptive Pills ☐ Nexplanon Implant ☐ Paraguard Intrauterine Device (IUD)

☐ Mirena Intrauterine Device ☐ Natural Family Planning ☐ Diaphragm ☐ Spermicides ☐ None

Date you stopped using contraception: _____

PREGNANCY NOTES:

When was the first day of your last menstrual period?* ☐ DD/MM/YYYY ☐Unknown
Your age at the time of your very first period (onset of menses)* _____
Periods are*: ☐ Regular ☐ Irregular
How often do they occur?* _____days
How long do your periods last?* _____ days
Have you ever had any menstrual problems? ☐ Yes ☐ No

Date of positive pregnancy test: ☐ DD/MM/YYYY ☐ Date Unknown
Please specify type of test* ☐ Urine/Home Pregnancy Test ☐ Blood test

What was your pre-pregnancy weight?* _____

Symptoms since your last menstrual period, *check all that apply*:
☐ No concerns ☐ Vaginal Bleeding ☐ Abdominal pain ☐ Headaches ☐ Dizziness
☐ Changes in vision ☐ Nausea ☐ Vomiting ☐ Difficulty keeping down oral fluids for 24 hours or more
☐ Lack of appetite ☐ Pain with urination ☐ Back pain ☐ Fever ☐ Constipation

Have you had any Emergency Room visits during this pregnancy?* ☐ Yes ☐ No
If yes, date: DD/MM/YYYY
Reason: _____
Details on the symptoms that warranted your ER visit or other symptoms you would like us to be aware of? _____
Do you have a history of infertility?* ☐ Yes ☐ No
If yes, what treatment have you undergone _____

GYN HISTORY:

☐ Polycystic Ovarian Syndrome (PCOS) ☐ Fibroids ☐ Endometriosis ☐ Pelvic pain ☐ Infertility
☐ Heavy periods ☐ Painful periods ☐ Bleeding between periods ☐ Sexual abuse/assault
☐ Uterine abnormalities
Comments: _____
Date of last Pap Smear ☐ _____ ☐ Unknown ☐ I have never had a pap smear
Results:* ☐ Normal ☐ Abnormal ☐ I have never had a pap smear
Abnormal pap smear follow up:*
☐ No history of an abnormal pap smear ☐ Repeat Pap Smear ☐ Colposcopy ☐ Cryotherapy
☐ Loop Electrode Excision Procedure (LEEP

FAMILY OBSTETRICAL HISTORY:

Your birth weight ___ lb ___ oz
Father's birth weight ____lb___ oz
Any family history of trauma associated with childbirth in your immediate family ☐ Yes ☐ No

PREGNANCY SUMMARY*

Total number of pregnancies	Number of Full Term Deliveries	Number of Preterm Deliveries	Number of miscarriages	Number of Abortions	Number of Vaginal Deliveries	Number of C-Section Deliveries	Number of Children Living

PREGNANCY NOTES/HISTORY: *list all delivery dates, please include any miscarriages or abortions*

Delivery Date	Sex of Baby	Weight	Gestation age in weeks	Hours in Labor	Type of Delivery	Anesthesia	Place of Delivery	Comments/Complications

Do you have any religious or cultural beliefs that may affect your obstetrical care? *Check all that apply*

☐ No Restrictions ☐ Decline blood products and/or blood transfusions ☐ Decline vaccinations

☐ Other: _____

For past pregnancies, have you been diagnosed with any of the following? *Check all that apply*

☐ Anemia ☐ Gestational Diabetes ☐ Intrauterine Growth Restriction (IUGR) ☐ Incompetent Cervix

☐ High Blood Pressure in Pregnancy ☐ Post Partum Depression ☐ Uterine/Placental Infection

☐ Too much amniotic fluid (Polyhydramnios) ☐ Too little amniotic fluid (Oligohydramnios)

☐ Previous C-Section Delivery ☐ Stillbirth ☐ Uncomplicated Past Pregnancy(s)

PERSONAL MEDICAL HISTORY*

Seasonal Allergies: ☐ None ☐ Yes, please list:_____

Anemia/Blood Disorder: ☐ Yes ☐ No *If yes*, date/comments:_____

Asthma/Lung Disorders: ☐ Yes ☐ No *If yes*, date/comments:_____

Autoimmune Disorder: ☐ Yes ☐ No *If yes*, date/comments:_____

Blood Transfusion: ☐ Yes ☐ No *If yes*, date/comments:_____

Breast Disorders: ☐ Yes ☐ No *If yes*, date/comments:_____

Depression: ☐ Yes ☐ No *If yes*, date/comments:_____

Anxiety/Psychiatric Disorder : ☐ Yes ☐ No *If yes*, date/comments: _____

Type I Diabetes: ☐ Yes ☐ No *If yes*, date/insulin type/dose, etc:_____

Type 2 Diabetes : ☐ Yes ☐ No *If yes*, date/treatment:_____

Endocrine Disorder: ☐ Yes ☐ No *If yes*, date/treatment:_____

PERSONAL MEDICAL HISTORY CONTINUED…

High Blood Pressure: ☐ Yes ☐ No *If yes*, date/comments:_____

Heart Disease: ☐ Yes ☐ No *If yes*, date/comments:_____

Liver Disease: ☐ Yes ☐ No *If yes*, date/comments:_____

Neurological Disorders (i.e. strokes, seizures, migraines): ☐ Yes ☐ No

If yes, date/comments:_____

Kidney Disease: ☐Yes ☐ No *If yes*, date/comments:_____

What is your blood type? ☐ Unknown ☐ O ☐ A ☐ B ☐ AB --- ☐ Positive ☐ Negative ☐ Unknown

Have you ever received Rhogam in the past? ☐ Yes ☐ No

If you have a negative blood type, have you ever been informed that you are Rh Sensitized?

☐ Yes ☐ No ☐ Unknown ☐ I do not have a negative blood type

Thyroid Disorder: ☐No ☐ Hypothyroid ☐ Hyperthyroid date/comments:_____

History of physical trauma (i.e. physical abuse, motor vehicle accident, etc): ☐ Yes ☐ No

If yes, Date/Comments:_____

Have you ever had complications with anesthesia? ☐ Yes ☐ No

If yes, dates/comments:_____

Cancer: ☐ Yes ☐ No If yes, date/type/comments:_____

Gastrointestinal Problems: ☐ Yes ☐ No

Musculoskeletal Problems: ☐ Yes ☐ No If yes, comments:_____

SUBSTANCE USE:*

Smoking Tobacco: ☐Yes ☐No Quit Date:_____

Prior to pregnancy I smoked _____ cigs/day I currently smoke _____ cigs/day

Chewing Tobacco: ☐ Yes ☐ No Quit Date:_____

Prior to pregnancy I chewed _____ cans/day I currently chew _____ cans/day

Alcohol Use: ☐ Yes ☐ No

Prior to pregnancy I drank _____ drinks/day I currently drink ____ drinks/day

Illicit Drug Use: ☐ Yes ☐ No *If Yes*, what type:_____

Prior to pregnancy I used drugs _____ times/day

I currently use drugs _____ times/day Quit Date:_____

Do you have any concerns about substance use or would like information on how to quit?

☐ Yes ☐ No *If yes*, please explain: _____

LIST ANY SURGICAL PROCEDURES YOU HAVE HAD DONE:

Surgery	Date

Have you ever been admitted to the hospital for any reason? ☐ Yes ☐ No ☐ Childbirth Only

If yes, explain:_____

IMMEDIATE FAMILY HISTORY:* (Parents, Siblings, Grandparents)
Please specify if person(s) is on maternal or paternal side of your family.
Include age of diagnosis if known.

Heart Disease ☐ Yes ☐ No List:_____
Heart Attack ☐ Yes ☐No List:_____
High Blood Pressure ☐ Yes ☐ No List:_____
Thyroid Disorder ☐ Yes ☐ No List:_____
Autoimmune Disorder ☐ Yes ☐ No List: _____
Tuberculosis ☐ Yes ☐ No List:_____
Diabetes ☐ Yes ☐ No List:_____
Chronic Renal Disease ☐ Yes ☐ No List: _____
Cancer ☐ Yes ☐ No List: _____
Stroke ☐ Yes ☐ No List: _____
Seizure Disorder ☐ Yes ☐ No List: _____
Psychiatric/Mental Health Disorder ☐ Yes ☐ No List: _____
Other (please describe)_____
Family History Knowledge Limited/Unknown ☐ Yes ☐ No Comments: _____

GENETIC SCREENING:* – *these questions are for you, the father of the baby and both your immediate family members to the best of your knowledge. If unknown, check 'No'. (Patient = Your personal history)*

Your current age _____ Father of the baby's current age_____
Neural Tube Defects (spina bifida/anacephaly) ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s) _____
Down Syndrome ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s) _____
Congenital Heart Defect ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Cystic Fibrosis ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Tay-Sachs, Thalassemia ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Canavan Syndrome ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Autism ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
If yes, has the person(s) diagnosed with Autism been tested for Fragile X? ☐ Yes ☐ No ☐ Unknown
Mental Retardation ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____

GENETIC SCREENING CONTINUED….

Muscular Dystrophy ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Sickle Cell Disease ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Cleft Lip/Cleft Palate ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Other Inherited Genetic Disorder or Birth Defects ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
If yes, explain:_____
Maternal Metabolic Disorder (i.e. PKU, Diabetes)☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
Recurrent Pregnancy Loss or Stillbirth ☐ No History ☐ Patient ☐ Father of Baby
☐ Family Member(s)_____
☐ Father of the Baby's Personal/Family History is unknown
Are you interested in having chromosomal blood testing (i.e. Harmony Prenatal Test/Quad Screen) during this pregnancy? ☐ Yes ☐ No ☐ I would like to discuss further at my appointment

EXPOSURE/INFECTION HISTORY:* *(Patient = Your Personal History)*

HIV ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
Genital Herpes ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date of last outbreak/Comments: _____
Gonorrhea ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date/Comments: _____
Chlamydia ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date/Comments: _____
HPV ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date/Comments: _____
Syphilis ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date/Comments: _____
Genital Warts ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date of last outbreak/Comments:_____
Hepatitis ☐ No History ☐ Patient ☐ Father of Baby/Current Sexual Partner
If yes, date/Comments: _____

Have you had a rash or viral illness since your last menstrual period? ☐ Yes ☐ No
If yes, location/treatment:_____
Do you have a history of chickenpox or were you vaccinated for chickenpox (varicella) as a child?
☐ Yes ☐ No

EXPOSURE/INFECTION HISTORY CONTINUED…

Have you had any exposures to a viral illness, radiation, X-rays, toxoplasmosis (cat litter boxes), Fifth's Disease, or cytomegalovirus (CMV) since your last menstrual period? ☐ Yes ☐ No

If yes, please specify/explain:_____

Do you have any cats in the home? ☐Yes ☐ No

If yes, pregnant women should not change the litter box due to the risk of toxoplasmosis which is a parasite in cat feces. Who changes the litter box in your home? _____

Have you ever been diagnosed with Methicillin Resistant Staph Aureus Infection (MRSA)?

☐ Yes ☐ No *If yes*, date/comments:_____

Date of last Flu Vaccine ☐ _____ ☐ unknown

Date of last Tetanus Diphtheria Pertussis (Whooping Cough) Vaccine ☐_____ ☐ unknown

DELIVERY PLAN:

☐ Vaginal delivery ☐ Repeat Cesarean Section ☐ Trial of Labor after Cesarean Section Delivery

Feeding Method: ☐ Breastfeed ☐ Bottle feed ☐ Breastfeed and Bottle Feed ☐ Undecided

Are you planning an epidural for pain relief in labor? ☐ Yes ☐ No ☐ Undecided

If you have a baby boy, do you plan on having him circumcised? ☐ Yes ☐ No ☐ Undecided

Are you planning permanent sterilization after this pregnancy?

☐ No, thank you ☐ Yes - Tubal Ligation ☐ Yes – Vasectomy for husband/partner

Do you have other plans for birth control after this pregnancy?

☐ No, thank you ☐ Natural Family Planning ☐ Mirena IUD ☐ Paraguard IUD ☐ Nexplanon

☐ Birth Control Pills ☐ Condoms ☐ Diaphragm ☐ Spermicides ☐ Same Sex Relationship

☐ I would like to discuss my options with my provider

PEDIATRICIAN CHOICE: – *all babies will be seen by the pediatrician on call through Black Hills Pediatrics during their hospital stay.* Upon discharge I plan to have my baby(s) follow up with:

☐ Continue Care with pediatrician who is on call when I deliver

☐ Black Hills Pediatrics/Choice of Provider at this facility: _____

☐ Current Pediatrician/Family Practice Provider: _____

☐ Provider/Pediatrician at Ellsworth Airforce Base

☐ Undecided

Other pregnancy info you would like us aware of (i.e. currently breastfeeding another child, planning to move to another location during this pregnancy, surrogacy pregnancy, pregnancy conceived with sperm donor, etc.):

_____

_____

Thank you and congratulations on your pregnancy! If we have any questions, we will contact you by phone prior to your appointment. Return calls from Black Hills OB/GYN may show up as "unknown" or "restricted" for some phone carrier services. If you have voicemail capabilities on your phone, please have it set up so we may leave a message if you are unable to answer at the time of our call. If you have any questions or concerns that you feel need addressed before your scheduled appointment, please contact us at 605-343-9224.

We look forward to seeing you! - The Staff at Black Hills Obstetrics and Gynecology