KAISER PERMANENTE®

OB/GYN Care Visit

This worksheet is used to help you and your health care provider determine your pregnancy care needs. We will use this form to enter information into Kaiser Permanente's secure medical record system.

Kaiser Permanente values your privacy. Your answers will be kept confidential.

Personal Information	**CLINIC USE ONLY**
Your name:	**In Epic: Patient Demographic Information**
Occupation:	
Are you married? ❒ Yes ❒ No	
Are other people living with you? ❒ Yes ❒ No If **yes**, who lives with you:	
Religion:	
Language spoken: If you need an interpreter, in what language?	
Ethnic background:	
Father of Baby	**CLINIC USE ONLY**
Name:	**In Epic: Father of Baby**
Age:	
Occupation:	
Ethnic background:	
Religion:	
Home phone number:	
Work phone number:	
Cell phone number:	
Have you ever had genetic testing? ❒ Yes ❒ No If **yes**, what were you tested for:	

Last Menstrual Period Information	**CLINIC USE ONLY**
Do you know the day your last menstrual period started? ❒ Yes ❒ No	**In Epic: New OB Questionnaire**
If **yes**, when did your last menstrual period start (month/day/year):	
Are you sure of this date? ❒ Yes ❒ No	
Was your last period normal? ❒ Yes ❒ No	
If your periods are not regular: What is the ***shortest*** time (in days) from one period to the next? _____ What is the ***longest*** time (in days) from one period to the next? _____	
How many **days** from the beginning of one period to the beginning of the next?	
Symptoms since last menstrual period Do you currently have any of the following symptoms: ❒ abdominal pain ❒ blood in the stools or urine ❒ chest pain ❒ shortness of breath ❒ coughing ❒ vomiting ❒ pain on urination ❒ vaginal discharge ❒ vaginal bleeding ❒ nausea ❒ headache ❒ constipation	

Birth Control and Breastfeeding	**CLINIC USE ONLY**
Were you taking birth control at the time of conception? ❒ Yes ❒ No	**In Epic: New OB Questionnaire**
Did you take birth control pills before becoming pregnant? ❒ Yes ❒ No	
When did you stop taking them (month/day/year):	
Were you breastfeeding at the time of conception? ❒ Yes ❒ No	

Vaccinations and Tests	**CLINIC USE ONLY**
Have you had chicken pox or been vaccinated against Varicella? ❒ Yes ❒ No	**In Epic: New OB Questionnaire**
Have you ever received the Hepatitis B vaccine? ❒ Yes ❒ No	
When did you receive your last tetanus vaccine (Tdap):	
We will test you for Hepatitis B. Do you object to this? ❒ Yes ❒ No	
We will test you for HIV. Do you object to this? ❒ Yes ❒ No	

Pregnancy History	**CLINIC USE ONLY**
Please answer the following questions for each pregnancy you've had. If you've never been pregnant, please skip to the next section.	**In Epic: OB History**
How many pregnancies have you had?	
Date of birth or end of pregnancy:	
How many weeks?	
What is the baby's name?	
How much did the baby weigh?	
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:	
How long were you in labor?	
Where was the baby delivered?	
What was the name of your pregnancy care provider?	
Did you have anesthetic? ❒ Yes ❒ No If yes, what kind? ❒ Subarachnoid block ❒ IV Analgesic ❒ Local ❒ Spinal ❒ General ❒ Epidural ❒ Pudendal	
If you've had a baby, please check the following for your birth: ❒ Vaginal delivery ❒ Cesarean section ❒ Help of a vacuum extractor ❒ Help of forceps ❒ Breech birth ❒ Multiple babies (ie: twins, triplets) ❒ Pregnancy termination (abortion) ❒ Ectopic (tubal) pregnancy ❒ Stillbirth ❒ Miscarriage	
What was the sex of the baby? ❒ Male ❒ Female ❒ Unknown ❒ Other	
Is this child still living? ❒ Yes ❒ No	
Were there any complications? ❒ Yes ❒ No If yes, what?	
Did you go full term or deliver early? ❒ Full term ❒ Premature delivery	

Second pregnancy (if applicable):	**CLINIC USE ONLY**
Date of birth or end of pregnancy:	
How many weeks?	
What is the baby's name?	
How much did the baby weigh?	
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:	
How long were you in labor?	
Where was the baby delivered?	
What was the name of your pregnancy care provider?	
Did you have anesthetic? ❒ Yes ❒ No If yes, what kind? ❒ Subarachnoid block ❒ IV Analgesic ❒ Local ❒ Spinal ❒ General ❒ Epidural ❒ Pudendal	
If you've had a baby, please check the following for your birth: ❒ Vaginal delivery ❒ Pregnancy termination (abortion) ❒ Cesarean section ❒ Ectopic (tubal) pregnancy ❒ Help of a vacuum extractor ❒ Stillbirth ❒ Help of forceps ❒ Breech birth ❒ Multiple babies (ie: twins, triplets)	
What was the sex of the baby? ❒ Male ❒ Female ❒ Unknown ❒ Other	
Is this child still living? ❒ Yes ❒ No	
Were there any complications? ❒ Yes ❒ No If yes, what?	
Did you go full term or deliver early? ❒ Full term ❒ Premature delivery	

Third pregnancy (if applicable):	**CLINIC USE ONLY**
Date of birth or end of pregnancy:	
How many weeks?	
What is the baby's name?	
How much did the baby weigh?	
How long were you in labor?	
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:	
Where was the baby delivered?	
What was the name of your pregnancy care provider?	
Did you have anesthetic? ❒ Yes ❒ No If yes, what kind? ❒ Subarachnoid block ❒ IV Analgesic ❒ Local ❒ Spinal ❒ General ❒ Epidural ❒ Pudendal	
If you've had a baby, please check the following for your birth: ❒ Vaginal delivery ❒ Pregnancy termination (abortion) ❒ Cesarean section ❒ Ectopic (tubal) pregnancy ❒ Help of a vacuum extractor ❒ Stillbirth ❒ Help of forceps ❒ Breech birth ❒ Multiple babies (ie: twins, triplets)	
What was the sex of the baby? ❒ Male ❒ Female ❒ Unknown ❒ Other	
Is this child still living? ❒ Yes ❒ No	
Were there any complications? ❒ Yes ❒ No If yes, what?	
Did you go full term or deliver early? ❒ Full term ❒ Premature delivery	

Past Medical History

If you do not know the answer to any of the following questions, please leave blank.

Neurological

General neurological problems ❒ Yes ❒ No
Epilepsy ❒ Yes ❒ No
Migraines ❒ Yes ❒ No
Stroke ❒ Yes ❒ No
Seizures ❒ Yes ❒ No
Headaches ❒ Yes ❒ No

Psycho Social

Postpartum depression ❒ Yes ❒ No
Inpatient psychiatric care ❒ Yes ❒ No
Depression ❒ Yes ❒ No
Domestic violence ❒ Yes ❒ No
Forced sex ❒ Yes ❒ No
Substance abuse ❒ Yes ❒ No
Post traumatic stress disorder (PTSD) ❒ Yes ❒ No
Mood disorder ❒ Yes ❒ No
Difficulty coping ❒ Yes ❒ No

Endocrine

Thyroid disease ❒ Yes ❒ No
Diabetes mellitus ❒ Yes ❒ No
Infertility ❒ Yes ❒ No
Polycystic ovary syndrome (PCOS) ❒ Yes ❒ No

Respiratory

Tuberculosis ❒ Yes ❒ No
Asthma ❒ Yes ❒ No
Pneumonia ❒ Yes ❒ No
Pulmonary embolism ❒ Yes ❒ No
Other respiratory ❒ Yes ❒ No

Circulatory Problems

Hypertension ❒ Yes ❒ No
Coronary artery disease ❒ Yes ❒ No
Mitral valve prolapse ❒ Yes ❒ No
DVT ❒ Yes ❒ No
Irregular heartbeat ❒ Yes ❒ No
Rheumatic fever ❒ Yes ❒ No
Varicosities/ Phlebitis ❒ Yes ❒ No
Blood clot ❒ Yes ❒ No

Blood Disorders

Blood transfusion received ❒ Yes ❒ No
Refuse blood transfusion ❒ Yes ❒ No
Anemia ❒ Yes ❒ No
Rh incompatibility ❒ Yes ❒ No
Sickle cell anemia ❒ Yes ❒ No
Thalassemia ❒ Yes ❒ No
Clotting disorder ❒ Yes ❒ No

Breast History

Breast cancer ❒ Yes ❒ No
Nursing issue ❒ Yes ❒ No

Genito-Urinary

Frequent urinary tract infections (UTIs) ❒ Yes ❒ No
Pyelonephritis ❒ Yes ❒ No
Abnormal uterus ❒ Yes ❒ No
Ectopic pregnancies ❒ Yes ❒ No
Kidney disease ❒ Yes ❒ No

Gastrointestinal (GI) System

Liver disorder ❒ Yes ❒ No
GI disorder ❒ Yes ❒ No
Jaundice ❒ Yes ❒ No

Rheumatoid Arthritis

Rheumatoid arthritis ❒ Yes ❒ No
Lupus ❒ Yes ❒ No

Past Medical History — continued

If you do not know the answer to any of the following questions, please leave blank.

Infection

HIV/AIDS	❒ Yes	❒ No	Neonatal GBS	❒ Yes	❒ No
Hepatitis B	❒ Yes	❒ No	MRSA	❒ Yes	❒ No
Hepatitis C	❒ Yes	❒ No	Genital warts	❒ Yes	❒ No
Chlamydia	❒ Yes	❒ No	HPV	❒ Yes	❒ No
Gonorrhea	❒ Yes	❒ No	Abnormal pap	❒ Yes	❒ No
Syphilis	❒ Yes	❒ No	Varicella (chickenpox)	❒ Yes	❒ No
Genital herpes	❒ Yes	❒ No			

Other medical history:

Past Surgical History

If you do not know the answer to any of the following questions, please leave blank.

Cesarean section	❒ Yes	❒ No	Cervical laser ablation	❒ Yes	❒ No
Conization	❒ Yes	❒ No	LEEP procedure	❒ Yes	❒ No
Cervical cryocauterization	❒ Yes	❒ No	Breast Augmentation/		
Gynecological surgical procedure	❒ Yes	❒ No	Reconstruction	❒ Yes	❒ No

Other surgical history:

Family History

If you don't know the answer to any of the following questions, please leave blank.
If you or the baby's father is adopted, fill out this section the best that you can.

Relationship	Thalassemia	Neural tube defect	Congenital heart defect	Down syndrome	Tay-Sachs	Sickle cell disease	Hemophilia	Muscular dystropy	Cystic Fibrosis	Huntington's chorea	Mental retardation	Autism	Fragile X	Other inherited disorder	Metabolic disorder	Child with birth defects	Miscarriages (many)	Stillbirth	Other genetic risks
Mother																			
Father																			
Sister																			
Brother																			
Grandmother (mother's side)																			
Grandfather (mother's side)																			
Grandmother (father's side)																			
Grandfather (father's side)																			
Dad of baby																			
Dad's family																			
Daughter																			
Son																			
Aunt (mother's side)																			
Uncle (mother's side)																			

Family History — continued

If you don't know the answer to any of the following questions, please leave blank.
If you or the baby's father is adopted, fill out this section the best that you can.

Relationship	Thalassemia	Neural tube defect	Congenital heart defect	Down syndrome	Tay-Sachs	Sickle cell disease	Hemophilia	Muscular dystropy	Cystic Fibrosis	Huntington's chorea	Mental retardation	Autism	Fragile X	Other inherited disorder	Metabolic disorder	Child with birth defects	Miscarriages (many)	Stillbirth	Other genetic risks
Aunt (father's side)																			
Uncle (father's side)																			
Other																			

Details:

Comments:

Social History

CLINIC USE ONLY

In Epic: Social

Alcohol and Drug Use

Do you drink alcohol? ❒ Yes ❒ No

If **yes**, how much do you usually drink in one week:

Do you use tobacco? ❒ Yes ❒ **No**

If **yes**, what type of tobacco do you use?

How long have you used tobacco?

Do you use other drugs? ❒ Yes ❒ **No**

Sexual Health

CLINIC USE ONLY

In Epic: Social

Are you sexually active? ❒ Yes ❒ No

If **yes**, what type of birth control do you use: