ROSENBERG Maternal-Fetal Medicine

1229 Broadway
Suite 201
Hewlett, NY 11557

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 (check one)

Pregnancy conceived via infertility treatment? YES ___ NO ___. If yes, [ ] IVF [ ] IUI (check one)

For IVF: Date of embryo transfer: ___/___/_____ [ ] 3 day transfer [ ] 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)

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

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

PLEASE RETURN THE COMPLETED INTAKE FORM TO:

RECEPTION@ROSENBERGMFM.COM

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