OB Screening Intake Form

(For New Obstetric Patients)

Patient Information

Patient Name: _____	DOB: _____	Contact #: _____
Date of Call/Visit: _____		

Pregnancy Information

■ Estimated Last Menstrual Period (LMP): _____
■ Estimated Gestational Age (if known): _____ weeks
■ Confirmed pregnancy test? ■ Yes ■ No
■ Where was test done? ■ Home ■ Lab ■ Another office

Pregnancy History

■ Gravida _____ Para _____
■ Previous miscarriages? ■ Yes ■ No How many? _____
■ Previous ectopic pregnancy? ■ Yes ■ No
■ History of C-section? ■ Yes ■ No # _____
■ History of preterm labor or birth? ■ Yes ■ No
■ History of preeclampsia/gestational hypertension? ■ Yes ■ No
■ History of gestational diabetes? ■ Yes ■ No

Current Symptoms / Concerns

■ Vaginal bleeding	■ Severe cramping
■ Severe nausea/vomiting	■ Pelvic pain
■ Fever/chills	■ Other urgent concern: _____

Medical History (Relevant to Pregnancy)

■ High blood pressure	■ Diabetes (Type 1 / Type 2)

■ Thyroid disorder	■ Seizure disorder
■ Autoimmune disease (e.g. lupus)	■ Clotting disorder
■ Mental health concerns (e.g. depression, anxiety)	■ Other: _____

Medications / Allergies

Current medications: _____
Allergies: _____

Social History

■ Tobacco use	■ Alcohol use
■ Illicit drug use	■ Support system at home: _____

Risk Stratification (For Scheduling)

■ Routine OB (no urgent issues) → Schedule New OB Intake Visit
■ High-Risk OB (based on history or current symptoms) → Flag for provider review before scheduling
■ Urgent Concerns (bleeding, severe pain, possible ectopic, severe hyperemesis) → Same-day or ER referral

Staff Review

Staff Initials: _____	Provider Review Needed: ■ Yes ■ No