New Patient Prenatal Intake Form

*Welcome to **Mahogany Medical**! We look forward to providing quality medical care for you. In order for us to better serve you, please kindly fill out the information below to the best of your knowledge.*

MAHOGANY
MEDICAL CLINIC

Date *(mm/dd/yyyy)*: _____

DEMOGRAPHIC

First Name *(nickname if applicable)*: _____

Middle name: _____ Last Name: _____

Address: _____ Postal code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: _____ Date of Birth *(mm/dd/yyyy)*: _____

Alberta Health Care Number: _____

Emergency Contact Name: _____

Phone number: _____ Relationship: _____

Family Physician: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Common-Law ☐ Married ☐ Divorced

Occupation: _____

Partners Name: _____

Partners Ethnicity: _____

Partners Occupation: _____

ALLERGIES

Medication Allergy: _____ Reaction: _____

Non-medication Allergy: _____ Reaction: _____

Do you carry an Epi-Pen? ☐ YES ☐ NO

MEDICATIONS

Prescription medications (ie. diclectin):

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

MEDICATIONS

Over the counter medications / supplements / vitamins (ie. Prenatal vitamins):

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

PRENATAL HISTORY / CURRENT

Pregnancy History:

No. of pregnancies: _____ No. of deliveries: _____ Ectopic: _____

No. of miscarriages: _____ No. of terminations: _____ Stillborn: _____

Date	Hospital	Type of delivery	No. of weeks	Complications	Birth weight	Child's name

Current Pregnancy:

Dating Ultrasound: _____ Due Date: _____ LMP: _____

Last menstrual period

FAMILY HISTORY

Family History:

- Diabetes / Gestational Diabetes ☐
- Heart Disease ☐
- High Blood Pressure / Pre-eclampsia ☐
- Birth defects / Syndrome / Malformations ☐
- Depression / Anxiety / Bipolar Disease ☐
- Twin / Triplets ☐
- Other ☐
- Genetic/Hereditary Risks to Fetus ☐
  (ie. thalasemmia, familial genes)

PERSONAL HISTORY

Personal History:

- Asthma ☑
- Auto-Immune *(ie. RA, Crohns)* ☐
- Bleeding / Clotting disorder ☐
- Heart Disorder ☐
- Gynecological / Ovarian Cyst ☐
- Thyroid disorder ☐
- High Blood Pressure / Pre-eclampsia ☐
- Diabetes / Diabetes in Pregnancy ☐
- Epilepsy / Seizures ☐
- Kidney Stones / UTI ☐
- Hepatitis / Liver Disease ☐
- GI disorder ☐

PERSONAL HISTORY

Personal History Continued:

HIV / AIDS ☐

Sexually transmitted infection / HPV / Herpes ☐

Tuberculosis ☐

Chicken Pox / Varicella Vaccine ☐

Depression / Anxiety ☐

Assisted Conception *(IVF/IUI, etc)* ☐

Anesthetic Problems ☐

Other ☐

_____

SURGICAL HISTORY

Past Surgical History (please include wisdom teeth, LEEP, colonoscopy, eye surgery if applicable):

Date of surgery	Type of surgery	Reason for surgery

OTHER RISKS

Do you have cats at home? Who changes the litter? _____

Are you concerned about any work place hazard? _____

Are there any smokers in the home? _____

In the last 6 months, have you travelled to any countries with ZIKA virus? _____

_____

Any other concerns? _____

LIFESTYLE

Do you smoke? ☐ YES ☐ NO

Before Pregnancy: ____ Cigs / day

In Pregnancy: ____ Cigs / day

Do you drink alcohol? ☐ YES ☐ NO

Before Pregnancy: ____ Drinks / day

In Pregnancy: ____ Drinks / day

Have you / do you use any recreational drugs? ☐ YES ☐ NO

☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Heroin ☐ Other