

NOB Intake Form

Pregnancy History:

Date (month/year):
EGA (weeks):
Outcome (vaginal/vacuum/cesarean/forceps):
Birth Weight: Pounds: Ounces:
Complications:
Comments:

Date (month/year):
EGA (weeks):
Outcome (vaginal/vacuum/cesarean/forceps):
Birth Weight: Pounds: Ounces:
Complications:
Comments:

Date (month/year):
EGA (weeks):
Outcome (vaginal/vacuum/cesarean/forceps):
Birth Weight: Pounds: Ounces:
Complications:
Comments:

Date (month/year):
EGA (weeks):
Outcome (vaginal/vacuum/cesarean/forceps):
Birth Weight: Pounds: Ounces:
Complications:
Comments:

Date (month/year):
EGA (weeks):
Outcome (vaginal/vacuum/cesarean/forceps):
Birth Weight: Pounds: Ounces:
Complications:
Comments:

NOB Intake Form

Medical/GYN/Psych History:

Problem:	Comments:
Cardiac: Congenital Heart Disease	
Cardiac: Cardiac Murmurs	
Cardiac: Hypertension	
Cardiac: PSVT (Paroxysmal Supraventricular Tachycardia)	
Cardiac: Valvular Disease	
Endocrine: Asthma/Reactive Airway Disease	
Endocrine: DVT/PE (blood clots in legs or lungs)	
Endocrine: Diabetes	
Endocrine: Hyperthyroid	
Endocrine: Hypothyroid	
GI: Gallstones	
GI: Crohn's Disease	
GI: Diverticulitis	
GI: Gastric Reflux (GERD)	
GI: Hepatitis	
GI: Irritable Bowel Syndrome	
GI: Pancreatitis	
GI: Peptic Ulcer Disease	
GI: Ulcerative Colitis	
HEME: Anemia	
HEME: Bleeding Disorder	
HEME: DVT/PE (blood clots in legs or lungs)	
HEME: Sickle Cell Disorders	
ID: Diverticulitis	
ID: Hepatitis	
ID: MRSA	
ID: Pelvic Inflammatory Disease	
ID: Pyelonephritis	
ID: STD/STI- Chlamydia, Gonorrhea, Herpes, Trichomoniasis or Syphilis	
ID: Tuberculosis	
Nephro: Pyelonephritis	
Nephro: Renal Stones	
Nephro: Urinary Tract Infections	
Nephro: Epilepsy/Seizure	
Neuro: Headaches or Migraines	
Neuro: Transient Ischemic Attack (TIA)	
Neuro: Traumatic Brain Injury	

Medical/GYN/Psych History (Cont.):

Problem:	Comments:
OB/GYN:	Cerclage (current or past pregnancy)
OB/GYN:	Chronic Pelvic Pain
OB/GYN:	Endometriosis
OB/GYN:	Abnormal PAP
OB/GYN:	History of Cervical/Uterine Procedure (LEEP)
OB/GYN:	Known Uterine Anomaly
ONC:	Cancer/Neoplasm/Malignancy (state location):
Ophtho:	Diabetic Retinopathy
Ophtho:	Glaucoma
Ophtho:	Blindness
Ophtho:	Arthritis
Ortho:	Fracture
Ortho:	Joint Dislocation
Ortho:	Low Back Pain
Ortho:	Rheumatoid Arthritis
Psych:	ADHD
Psych:	Depression
Psych:	Mania
Psych:	PTSD
Psych:	Psychotic Disorder
Psych:	Substance Abuse

Surgical History: Procedure: Date:

History of Blood Transfusion: No Yes
Date
Reaction?
Indication

Family History:

Problem:	Family Member (only mother, father and siblings):
Cardiac:	Congenital Heart Disease
Cardiac:	Congestive Heart Failure
Cardiac:	Coronary Artery Disease
Cardiac:	Hypertension

NOB Intake Form

Family History (Cont.):

Problem:	Family Member:
Cardiac:	Sudden Cardiac Death
Endocrine:	DVT/PE (blood clots in legs or lungs)
Endocrine:	Diabetes
Endocrine:	Hyperthyroid
Endocrine:	Hypothyroid
GI:	Crohn's Disease
GI:	Hepatitis
HEME:	Bleeding Disorder
HEME:	Sickle Cell Disorders
ID:	Hepatitis
ID:	Tuberculosis
Neuro:	Epilepsy/Seizure
Neuro:	CVA (Stroke)
Neuro:	Transient Ischemic Attack
ONC:	Cancer/Neoplasm/Malignancy:
Ophtho:	Macular Degeneration
Ortho:	Rheumatoid Arthritis
Psych:	Psychotic Disorder
Psych:	Substance Abuse
Rheum:	SLE (Lupus)

Social History:

Family Situation (Homemaker, Deployed Spouse etc.):

Tobacco Use:	NO	YES	Amount
Alcohol Use:	NO	YES	Amount
Recreational Drug Use:	NO	YES	Amount
Desire to quit any of the above:	YES	NO	

NOB Intake Form

Genetic History:

Condition	Family Member Relation	
Thalassemia		
Down Syndrome		
Heart or Kidney problems		
Spina Bifida/NTD		
Cystic Fibrosis		
Sickle Cell Disease		
Tay-Sachs		
Canavan Disease/Familial Dysautonomia		
Frequent Miscarriage/Still Birth		
Type 1 Diabetes		
Birth Defects		
Mental Retardation/Autism		
Older than 35 at time of birth		
Muscular Dystrophy		
Hemophilia		
Huntington Chorea		

Desire Genetic Testing or Screening? :	YES	NO
Desire Cystic Fibrosis Screening? :	YES	NO

Relay Health – Secure Messaging

**This program is designed so that you can communicate with your provider, receive lab results, ask questions, etc.

Please legibly complete this form and return to a staff member so that we can register you! Thanks so much!!

Name: _____ DOB: _____

DOD ID# (located on your military ID card): _____

Mailing address: _____

E-mail address (this is where you will receive messages from RelayHealth):

If pregnant, estimated due date: _____

“Care with Honor”

