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