DATE: _____

NAME: _____
LAST FIRST MIDDLE

ID #: _____ HOSPITAL OF DELIVERY: _____

NEWBORN CARE PROVIDER: _____ REFERRED BY: _____

Dr. John V. McInerney
11824 Southwest Highway
Palos Heights,Ill.60463

PRIMARY PROVIDER/GROUP: _____

FINAL EDD: _____ ADDRESS: _____

BIRTH DATE: AGE: RACE: MARITAL STATUS: S M W D SEP MONTH DAY YEAR	ADDRESS: _____
OCCUPATION: EDUCATION. (LAST GRADE COMPLETED)	ZIP: _____ PHONE: _____ (1) _____ (2)
LANGUAGE: ETHNICITY:	E-MAIL:
HUSBAND/DOMESTIC PARTNER: PHONE:	INSURANCE CARRIER/MEDICAID #:
FATHER OF BABY: PHONE:	POLICY #:
	EMERGENCY CONTACT: PHONE:

TOTAL PREG:	FULL TERM:	PREMATURE:	AB, INDUCED:	AB, SPONTANEOUS:	ECTOPICS:	MULTIPLE BIRTHS:	LIVING:

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _____ DAYS MENARCHE: _____ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION PRIOR MENSES: _____ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + ____/____/____
☐ FINAL: _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
A. DRUG/LATEX ALLERGIES/ REACTIONS		
B. ALLERGIES (FOOD, SEASONAL, ENVIRONMENTAL)		
1. NEUROLOGIC/EPILEPSY		
2. THYROID DYSFUNCTION		
3. BREAST DISEASE		
4. PULMONARY (TB, ASTHMA)		
5. HEART DISEASE		
6. HYPERTENSION		
7. CANCER		
8. HEMATOLOGIC DISORDERS		
9. ANEMIA		
10. GASTROINTESTINAL DISORDERS		
11. HEPATITIS/LIVER DISEASE		
12. KIDNEY DISEASE/UTI		
13. VARICOSITIES/PHLEBITIS		
14. DIABETES (TYPE 1 OR TYPE 2)		
15. GESTATIONAL DIABETES		
16. AUTOIMMUNE DISORDERS		
17. DERMATOLOGIC DISORDERS		

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
18. OPERATIONS/HOSPITALIZATIONS (YEAR & REASON)		
19. GYN SURGERY		
20. ANESTHETIC COMPLICATIONS		
21. HISTORY OF BLOOD TRANSFUSIONS		
22. INFERTILITY		
23. ASSISTED REPRODUCTIVE TECHNOLOGY		
24. UTERINE ANOMALY/DES		
25. HISTORY OF ABNORMAL PAP		
26. HISTORY OF STI		
27. PSYCHIATRIC ILLNESS		
28. DEPRESSION/POSTPARTUM DEPRESSION		
29. TRAUMA/VIOLENCE		

		PREPREG	PREG	# YEARS USE
30. TOBACCO (AMT/DAY)				
31. ALCOHOL (AMT/WK)				
32. ILLICIT/RECREATIONAL DRUGS (USES/WK)				
33. RELEVANT FAMILY HISTORY				
34. OTHER				

COMMENTS: _____

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PATIENT NAME: BIRTHDATE DATE

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11824 Southwest Highway
Palos Heights, Ill. 60463

GENETIC SCREENING*/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO
1. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80	○	○
2. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)	○	○
3. CONGENITAL HEART DEFECT	○	○
4. DOWN SYNDROME	○	○
5. TAY–SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)	○	○
6. CANAVAN DISEASE (ASHKENAZI JEWISH)	○	○
7. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)	○	○
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN AMERICAN)	○	○
9. HEMOPHILIA OR OTHER BLOOD DISORDERS	○	○
10. MUSCULAR DYSTROPHY	○	○
11. CYSTIC FIBROSIS	○	○
12. HUNTINGTON CHOREA	○	○
13. MENTAL RETARDATION/AUTISM	○	○
IF YES, WAS PERSON TESTED FOR FRAGILE X?	○	○
14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER	○	○
15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)	○	○
16. BIRTH DEFECTS NOT LISTED ABOVE	○	○
17. RECURRENT PREGNANCY LOSS OR A STILLBIRTH	○	○
18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD	○	○
IF YES, AGENT(S) AND STRENGTH/DOSAGE		
19. ANY OTHER	○	○

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

INFECTION HISTORY

	YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB	○	○
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES	○	○
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD	○	○
4. PRIOR GBS-INFECTED CHILD	○	○

5. HISTORY OF STIs: GONORRHEA, CHLAMYDIA, HPV, SYPHILIS, PID (CIRCLE ALL THAT APPLY)
6. HIV INFECTION YES ○ NO ○
7. HISTORY OF HEPATITIS
8. OTHER (SEE COMMENTS)

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

IMMUNIZATIONS	YES (MONTH/YEAR) ___/___	NO	IF NO, POSTPARTUM VACCINE INDICATED?
TDAP or TD		☐	
INFLUENZA*		☐	
VARICELLA*		☐	
MMR*		☐	
HEPATITIS A (WHEN INDICATED)		☐	
HEPATITIS B (WHEN INDICATED)		☐	
MENINGOCOCCAL (WHEN INDICATED)		☐	
PNEUMOCOCCAL (WHEN INDICATED)		☐	

*All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the MMR and varicella vaccines postpartum if needed.

INITIAL PHYSICAL EXAMINATION

DATE: ___/___/___ WEIGHT: _____ HEIGHT: _____ BMI: _____ BP: _____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. TEETH	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. SYMPTOMS SINCE LMP	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	_____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals): _____

EXAM BY: _____

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