Congratulations! Attached is the Obstetric Intake to register for prenatal care. Please fill these forms out completely as it will allow us to provide you with the most appropriate care during your pregnancy. If you answer *"Yes"* to any of the questions, please provide a brief explanation on the bottom of the second page. Complete all boxes, including *Total Pregnancies, Number of deliveries, Miscarriages, Ectopic pregnancies, Elective abortions and Living Children.*

*****DO NOT INCLUDE ANY SOCIAL SECURITY NUMBERS ANYWHERE IN THIS PACKET***** **PLEASE INCLUDE ALL DETAILS OF YOUR MEDICAL AND OBSTETRIC HISTORY SO WE CAN ENSURE YOU GET BOOKED WITH THE RIGHT PROVIDER TYPE**

When we receive your paperwork, a nurse will call you to schedule your first OB visit. This appointment will take place between 10-13 weeks of pregnancy based on the date of your last cycle, and will be with a nurse practitioner, midwife, or physician depending on your health history. All prenatal lab work will be ordered at this appointment.

If you are transferring from another OB clinic, please ensure you complete the **Authorization for Disclosure of Medical or Dental Information** form so that we may request your OB records. If you have had previous C-section deliveries, please complete a separate authorization for each one so that we can request an operative report from the facility you delivered at.

Return the completed packet by delivering it to the Women's Health Department front desk (NMCP, Building 2, 4th Floor) or faxing it to 757-953-4947.

If you have not heard from us within 14 business days from the day of submission, please call 757-953-4300 to ensure we received your intake paperwork.

Thank you very much, and we look forward to serving you!

HEIGHT:
PRE-PREGNANCYWEIGHT:
BMI:

OBSTETRICAL PATIENT INTAKE

Date:	Full Name:	DOD ID #:	DOB:
Street Address:		City:	
State:	Zip:	Cell#: Home #: Email:	Work #:
Emergency Contact Name:	Emergency Contact #:	Marital Status:	
First Day of your Last Menstrual Period:	Allergies and Reaction:	Current Medications:	

Total Pregnancies:	# Deliveries 37 Weeks or Greater	# Deliveries Less than 37 Weeks	# Miscarriages	# Elective Abortions	# Ectopics	# Living Children

PRE-PREGNANCY WEIGHT___________ **HEIGHT_________________**

****PLEASE LIST DETAILS TO "YES" ANSWERS ON THE BACK OF THIS PAGE AND LIST THE # ASSOCIATED WITH THAT ANSWER****

1. History of Diabetes / Gestational Diabetes?	( ) Yes ( ) No	26. Date of last Pap Smear?	
2. Hypertension? (High Blood Pressure)	( ) Yes ( ) No	27. History of Abnormal PAP? If so, what year?	( ) Yes ( ) No
3. Pre-eclampsia?	( ) Yes ( ) No	28. History of Sexually Transmitted Infection?	( ) Yes ( ) No
4. Autoimmune Disorder?	( ) Yes ( ) No	29. Do you or your partner have Genital Herpes?	( ) Yes ( ) No
5. Kidney Disease?	( ) Yes ( ) No	30. Uterine Anomalies?	( ) Yes ( ) No
6. Frequent Urinary Tract Infection?	( ) Yes ( ) No	31. Treatment for Infertility?	( ) Yes ( ) No
7. Neurologic Disorder / Epilepsy?	( ) Yes ( ) No	32. GYN Surgery?	( ) Yes ( ) No
8. Psychiatric History / Depression?	( ) Yes ( ) No	33. Recurrent pregnancy loss (>3) or stillbirth?	( ) Yes ( ) No
9. Hepatitis / Liver Disease?	( ) Yes ( ) No	34. Significant Family History (Cancer, Diabetes, etc)	( ) Yes ( ) No
10. Anemia that Required Medication?	( ) Yes ( ) No	35. Have you had the Chicken Pox? AGE?	( ) Yes ( ) No
11. Phlebitis / Varicose Veins?	( ) Yes ( ) No	36. Varicella Vaccine? AGE?	( ) Yes ( ) No
12. Thyroid Dysfunction?	( ) Yes ( ) No	37. Flu Vaccine? WHEN?	( ) Yes ( ) No
13. Pulmonary History (TB, Asthma, etc.)?	( ) Yes ( ) No	38. PPD? WHEN?	( ) Yes ( ) No
14. History of a Blood Transfusion?	( ) Yes ( ) No	39. Live with someone with TB or exposed to TB?	( ) Yes ( ) No
15. Negative Blood Type? (Rh)	( ) Yes ( ) No	40. High risk for Hepatitis?	( ) Yes ( ) No
16. Tobacco use prior to pregnancy?	( ) Yes ( ) No	41. Up To Date on Vaccinations?	( ) Yes ( ) No
17. Tobacco use since Last Menstrual Period?	( ) Yes ( ) No	42. History of Gastric Bypass Surgery?	( ) Yes ( ) No
18. Alcohol use prior to pregnancy?	( ) Yes ( ) No	43. Concerned about weight gain in pregnancy?	( ) Yes ( ) No
19. Alcohol use since Last Menstrual Period?	( ) Yes ( ) No	44. Nutrition Consult Requested?	( ) Yes ( ) No
20. Street Drug use prior to pregnancy?	( ) Yes ( ) No	45. Surgery/Hospitalizations other than childbirth?	( ) Yes ( ) No
21. Street Drug use since Last Menstrual Period?	( ) Yes ( ) No	46. Complications with Anesthesia?	( ) Yes ( ) No
22. Breast Concerns?	( ) Yes ( ) No	47. Any other chronic medical conditions?	( ) Yes ( ) No

OBSTETRICS PATIENT INTAKE FORM CONTINUED

1A. Will you be 35 or greater at time of delivery? ( ) Yes ( ) No			
For Questions 2- 15, have you or a family member been diagnosed with:			
2A. Thalassemia?	( ) Yes ( ) No	9A. Down Syndrome?	( ) Yes ( ) No
3A. Tay-Sachs Disease?	( ) Yes ( ) No	10A. Hemophilia? (Bleeding Disorder)	( ) Yes ( ) No
4A. Sickle Cell Disease or Trait? (Circle Which)	( ) Yes ( ) No	12A. Cystic Fibrosis?	( ) Yes ( ) No
5A. Neural Tube Defects? (Spina Bifida, Anencephaly)	( ) Yes ( ) No	13A. Huntington Chorea?	( ) Yes ( ) No
6A. Congenital Heart Defect?	( ) Yes ( ) No	14A. Mental Retardation	( ) Yes ( ) No
7A Muscular Dystrophy?	( ) Yes ( ) No	15A. Autism?	( ) Yes ( ) No
8A. Inherited Genetic or Chromosomal Disorders?	( ) Yes ( ) No	16A. Do you or the Father of the Baby have a child with birth defects?	( ) Yes ( ) No
****Circle ALL That Apply**** **Are you of African, Mediterranean, Haitian, Greek, Asian, Jewish, Cajun, or French Canadian descent? ( )Yes ( )No			

****IF YOU DESIRE CYSTIC FIBROSIS SCREENING, PLEASE ANSWER THE FOLLOWING QUESTIONS****

1B. What is the ethnicity of your mother?	3B. Is there a history of CF in your family?	( ) Yes ( ) No
2B. What is the ethnicity of your father?	4B. Do you have CF? If yes, do you have symptoms?	( ) Yes ( ) No

1C. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	( ) Yes ( ) No
2C. Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	( ) Yes ( ) No
3C. Within the last year, has anyone forced or threatened you to have sexual activities with them?	( ) Yes ( ) No

****PAST PREGNANCIES/DELIVERIES:**

Date: Month/Year	Weeks	Length of Labor	Birth Weight	Male or Female	C-Section or Vaginal Delivery	Anesthesia	Place of Delivery	Preterm Yes/No	Complications: Bleeding, Vacuum/Forceps Delivery, Shoulder Dystocia, etc.

****USE THE REST OF THIS PAGE TO EXPLAIN ANY "YES" ANSWERS.**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).
PRINCIPAL PURPOSE(S): DD Form 2870 collects patient data and a patient's, or their parent's or legal representative's, authorization for a military treatment facility or dental treatment facility or DoD health plan to use or disclose an individual's protected health information.
ROUTINE USE(S): To third parties or individuals as per your written authorization.
APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190). https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf
DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed and there will be a non-release of the protected health information. This form will not be used for authorization to disclose substance abuse information or treatment, if any, within your medical records nor will it be used to authorize the use or disclosure of psychotherapy notes, if any, within your medical records.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	☐ BOTH ☐ INPATIENT ☐ OUTPATIENT

SECTION II - DISCLOSURE

6. I AUTHORIZE ____________________ **TO RELEASE MY PATIENT INFORMATION TO:**
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
ATTN TEAM NURSE FOR: Green Team _____ Gold Team _____ Violet Team _____ Blue Team ____	620 JOHN PAUL JONES CIRCLE, BLDG 2 4TH FLOOR (4C&D) PORTSMOUTH, VA 23708
c. TELEPHONE *(Include Area Code)* (757) 953-4300	**d. FAX** *(Include Area Code)* (757) 953-4947

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION
	☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the
TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.ss
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to
obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

Reset

Genetic Counseling is available at Naval Medical Center Portsmouth. Please answer the questions below to see if this service may be helpful to you. Your medical care provider will review this form and give you guidance. Not every Yes answer will need referral.

Your Name: **DOD Number:**	**Date:**	
Your Partner's Full Name:		
Are You Adopted?*	Yes	No
Is Your Partner Adopted?*	Yes	No
Are you and your partner genetically related to each other?* (i.e. [1] cousins)	Yes	No
Have you and/or your partner had genetic testing? If yes, was it a large carrier panel? *(please provide a copy of the results to OB provider)* If yes, what were you tested for? *(please provide a copy of the results to OB provider)*	Yes Yes	No No
Are you pregnant?	Yes	No
If pregnant, was donor egg, donor sperm or donor embryo used?	Yes	No
Have you and/or your partner had 3 or more pregnancy losses? *(^If yes, OB provider will order karyotype(s), APs, and other labs as clinically indicated)*	Yes	No
*(*Genetic Consult)*		
Ancestry *(check all that apply)*	**You** (check all that apply)	**Partner**
African or African American~	[ ]	[ ]
Ashkenazi Jewish*	[ ]	[ ]
Asian/Pacific Islander'	[ ]	[ ]
Cajun or French Canadian*	[ ]	[ ]
European Caucasian (English, Irish, German, etc.)	[ ]	[ ]
Hispanic (Mexico, Puerto Rico, Central or South America)~	[ ]	[ ]
Indian (India)	[ ]	[ ]
Mediterranean (Greece, Italy, Turkey, etc.)'	[ ]	[ ]
Middle Eastern (Egypt, Iran, Iraq, Lebanon, etc.)	[ ]	[ ]
Native American	[ ]	[ ]
Southeast Asia (China, Laos, Vietnam, etc.)'	[ ]	[ ]
Other (write here)	[ ]	[ ]
*(~hgb electrophoresis, 'CBC, *Genetic Consult)*		
Medications/Supplements/Harmful Substances while pregnant		
Prescription medications - list them:	Yes	No
Over the counter medications - list them:	Yes	No
Vitamins/supplements - list them:	Yes	No
Smoking/Vaping (circle which) If yes, how much? Quit? Yes No Quit When?	Yes	No
Alcohol (beer, wine, liquor) If yes, how much? Quit? Yes No Quit When?	Yes	No
Street Drugs (marijuana, cocaine, heroin, ecstasy, etc.) If yes, what drug(s)? Quit? Yes No Quit When?	Yes	No
(OB provider to determine if exposures are significant and need referral)		

Personal and Family Health History Form Name:_________________________________

Personal and Family Health Conditions *(you, your family, partner, partner's family)* *[<u>Be very specific</u>, such as: my father's sister's son or partner's mother's brother]*	
Blindness under age 20yo (who?)	Yes No
Deafness under age 20yo (who?)	Yes No
Spina Bifida (who?)	Yes No
Anencephaly (who?)	Yes No
Hydrocephalus (water in brain) (who?)	Yes No
Muscular dystrophy (who?)	Yes No
Blood disorders (what? who?)	Yes No
Hemophilia (who?)	Yes No
Sickle cell disease/trait (who?)	Yes No
Thalassemia (who?)	Yes No
Cystic fibrosis (thick mucus in lungs) (who?)	Yes No
Spinal muscular atrophy (SMA) (who?)	Yes No
Tay Sachs disease (who?)	Yes No
Bone deformities (what? who?)	Yes No
Dwarfism (who?)	Yes No
Club Foot/Feet (who?)	Yes No
Extra/missing fingers/toes/bones/limbs (who?)	Yes No
Brittle bones under age 20yo (who?)	Yes No
Intellectual disability (what? who?)	Yes No
Autism (who?)	Yes No
Fragile X syndrome (who?)	Yes No
Cleft lip/cleft palate (who?)	Yes No
Marfan syndrome (who?)	Yes No
Ehlers Danlos - *Vascular type* (who?)	Yes No
Heart defect at birth needing surgery (who?)	Yes No
Cerebral Palsy (who?)	Yes No
Abnormal kidneys (what? who?)	Yes No
Cystic kidneys (who?)	Yes No
Extra or missing kidneys (who?)	Yes No
Dialysis at young age (who?)	Yes No
Chromosome syndrome (what? who?)	Yes No
Down syndrome (who?)	Yes No
Deletion or duplication syndrome (who?)	Yes No
Translocation (who?)	Yes No
Seizures (who?)	Yes No
Miscarriages (3 or more each) (who?)	Yes No
Stillbirth (who?)	Yes No
Infant death (who?)	Yes No
Other Genetic conditions (what? who?)	Yes No
Other birth defects (what? who?)	Yes No
(For page 2 - OB provider to determine if Genetic Counseling referral is indicated)	

Women's Health

Food and Nutrition in Pregnancy

Nutrition is especially important during pregnancy, and sometimes it can be hard to afford enough healthy food. We ask all our patients about access to food and provide all patients with information about community resources which can help.

Please tell us if these statements were often true, sometimes true, or never true, by circling your answers below.

Within the past 12 months I/we were worried whether our food would run out before we got money to buy more	Often true	Sometimes true	Never true
Within the past 12 months the food I/we bought just didn't last and I/we didn't have the money to get more.	Often true	Sometimes true	Never true

If either of these statements is sometimes true or often true for you, or if you have any other concerns about access to healthy food, these organizations may be able to help.

WIC helps to ensure that pregnant and post-partum patients, infants, and children under 5 years old can get enough healthy food to eat. WIC provides eligible families with vouchers to buy food and infant formula. Visit myvawic.org to check eligibility. Call your local WIC office to enroll.

Hampton Roads WIC Offices
Norfolk (757) 985-4856
Virginia Beach (757) 518-2798
Portsmouth (757) 393-5340
Chesapeake (757) 382-8608
Suffolk (757) 514-4721
Hampton (757) 594-7502

SNAP (Supplemental Nutrition Assistance Program) provides families with a debit card which can be used to buy food. Eligibility is based on monthly income and household size. Apply online at https://www.commonhelp.virginia.gov/

Virginia Peninsula Foodbank operates a mobile food pantry. For information on the mobile food pantry, and other local food banks, visit https://hrfoodbank.org/need-food/ or call 757-596-7188.

Patriot's Pantry provides food and baby supplies in their office in Virginia Beach, and at Liberty Military Housing at Oceana, Norfolk Pointe, Little Creek, and Whitehurst. The mobile Patriot's Pantry visits Ft. Eustis and Langley Air Force Base (registration is required for those locations). For more information, visit https://hamptonroads.asymca.org/services/food-assistance/

Foodbank of Southeastern Virginia and Eastern Shore provides a search tool which can help you find food resources near you. Visit https://foodbankonline.org or call 757-627-6599 or 877-HUNGERX (877-486-4379).

Link Hampton Roads provides food and clothing on a walk-in basis at 10413 Warwick Blvd, Newport News. For information call 757-595-1953 or visit https://www.linkhr.org/emergency-services-1

THRIVE Peninsula food bank in Newport News provides a week's worth of food for each household member. There are no income requirements. Call 757-877-6211 to arrange a pickup. https://www.thrivepeninsula.org/foodpantry

Eastern Virginia Medical School maintains a list of additional food resources, which can be found on their website. https://www.evms.edu/education/resources/community-engaged_learning/hopes/emergency_food_resources/