



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, you will receive a call 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.

Obstetric care is available at Naval Medical Center Portsmouth, Sewell's Point Branch Clinic, and Dam Neck Branch Clinic. Appointments are scheduled based on location availability. Submit packets online via the Genesis Secure Messaging Patient Portal found under "**Portsmouth NMCP OB/GYN New OB Packet Submission**" or return completed packet to the Women's Health Department located in building 2, floor 4 at NMCP, the Sewell's Point Branch Clinic or the Dam Neck Branch Clinic.

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

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT <i>(Title and Number)</i> Women's Health Departmental SOP	ISSUANCE DATE 16 Mar 2011
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LOCAL FORM TITLE *(Optional)*
OB/GYN Clinic No Show Policy Statement

**NO SHOW POLICY
OB/GYN CLINIC
Naval Medical Center Portsmouth**

We are committed to offering you and your family the best medical care available and delivering this care in a timely fashion. In an effort to accomplish this mission, we need your help. So, we ask that you carefully read the following policy and understand that we are committed to meeting your healthcare needs.

1. Active Duty:

- a. I understand that I am responsible for keeping my appointments and am requested to present **15 minutes** prior to my scheduled appointment time.
- b. I understand if I miss a scheduled appointment that my chain of command may be notified and this may result in being charged with an unauthorized absence.
- c. I understand if I am not able to keep my appointment, I will be held responsible and need to call the OB clinic 24 hours in advance to cancel my appointment and reschedule.

2. Family Members:

- a. I understand that I am responsible for keeping my appointments and am requested to present **15 minutes** prior to my scheduled appointment time.
- b. I understand that if I am not able to keep my appointment, I am held responsible and need to call the OB clinic 24 hours in advance to cancel my appointment and reschedule.
- c. Failure to call the OB clinic prior to my appointment will result in a "NO SHOW".

Clinic "NO SHOWS" result in setbacks to your treatment plan and prevents other patients from being scheduled in your place.

Patient's Signature: _____ Date: _____

Sponsor's Signature: _____ Date: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)</i>	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

MEDICAL RECORD - SUPPLEMENTAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date

REQUIRING DOCUMENT (<i>Title and Number</i>)	ISSUANCE DATE
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LOCAL FORM TITLE

GENETIC CARRIER SCREENING

Genetic carrier screening is a test that looks at your genes to determine whether you are a carrier of certain genetic disorders. A positive result tells you with greater than 99% certainty that you are a carrier of a specific genetic disorder, and you could be at risk of having an affected child. If a risk is identified, you may wish to consider genetic carrier screening for your partner, consult with your health-care provider, or pursue genetic counseling. If you are pregnant, prenatal testing can be performed to find out whether your baby has inherited the genetic disorder. We currently offer carrier screening for the following disorders:

Cystic fibrosis (CF) is a genetic disorder and leads to life-long illness. It causes the body to produce very thick mucus that can damage internal organs. It can lead to chronic lung infections, digestive problems, poor growth and infertility. Symptoms range from mild to severe, but do not affect intelligence. On average, CF patients live into their mid to late thirties. About 1 in every 3,500 babies born in the U.S. has cystic fibrosis. Screening of newborns for cystic fibrosis is now performed in every state.

Spinal muscular atrophy (SMA) is a genetic disorder that affects the control of muscle movement. It affects a person's ability to control their muscles, including those involved in breathing, eating, crawling and walking. SMA has different levels of severity, none of which affect intelligence. However, the most common form of the disorder causes death by age two. About 1 in every 6,000 to 1 in every 10,000 babies born in the US has SMA.

No test can detect 100% of genetic carriers. Even if your test results are negative, it is still possible that you could be a carrier of the genetic disorder, but the chance is small.

For the most accurate interpretation of test results, the laboratory needs correct information about your ethnic background, family history of genetic disorders and family relationships (especially paternity).

The decision to accept or decline genetic carrier screening is completely yours.

Your test results are confidential and will become a part of your medical record. Your test results will be sent only to the health-care provider who ordered the test, or his/her agent, unless otherwise authorized by you or required by law. Your health-care provider is responsible for interpreting the test results and explaining them to you. No other test will be performed and reported on your sample unless authorized by your health-care provider.

Before signing this form, I have had the opportunity to discuss genetic carrier screening with my health-care provider or someone he/she has designated. I understand that genetic counseling will be recommended if both I and my partner are carriers. My questions have been answered and I have all the information I need to make a decision at this time.

- | | |
|---|--|
| <input type="checkbox"/> I want carrier screening for CF | <input type="checkbox"/> I do not want carrier screening for CF |
| <input type="checkbox"/> I want carrier screening for SMA | <input type="checkbox"/> I do not want carrier screening for SMA |

Patient Name (please print)	Patient Signature
Witness Signature	Date

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
<small>PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - Last, first, middle: SSN: Sex: Date of Birth: Rank/Grade.)</small>	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT:
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

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?		Yes No
If yes, was it a large carrier panel? <i>(please provide a copy of the results to OB provider)</i>		Yes No
If yes, what were you tested for? <i>(please provide a copy of the results to OB provider)</i>		
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?		Yes No
<i>(^If yes, OB provider will order karyotype(s), APs, and other labs as clinically indicated)</i>		
<i>(*Genetic Consult)</i>		
Ancestry	<i>(check all that apply)</i>	You Partner <i>(check all that apply)</i>
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)		[] []
<i>(~hgb electrophoresis, 'CBC, *Genetic Consult)</i>		
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)		Yes No
If yes, how much? Quit? Yes No Quit When?		
Alcohol (beer, wine, liquor)		Yes No
If yes, how much? Quit? Yes No Quit When?		
Street Drugs (marijuana, cocaine, heroin, ecstasy, etc.)		Yes No
If yes, what drug(s)? Quit? Yes No Quit When?		
<i>(OB provider to determine if exposures are significant and need referral)</i>		

Personal and Family Health Conditions (you, your family, partner, partner’s family) <i>[Be very specific, such as: my father’s sister’s son or partner’s mother’s brother]</i>	Yes	No
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 - <i>Vascular type</i> (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
<i>(For page 2 - OB provider to determine if Genetic Counseling referral is indicated)</i>		



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.

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/>

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

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/