



## WMHP INTAKE - PREGNANCY

*Thank you for taking time to complete this form. The information collected will help us to offer guidance as you make decisions regarding your care and will be kept strictly confidential.*

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_/\_\_\_/\_\_\_ **AGE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE - HOME:** \_\_\_\_\_ **CELL:** \_\_\_\_\_ **WORK:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

### General Information

♦ **MARITAL STATUS**

- Never married / living alone
- Never married / living with partner
- Married – How long? \_\_\_\_\_ How many times? \_\_\_\_\_
- Divorced
- Widowed

♦ **GENDER OF YOUR SPOUSE/PARTNER**

- Male
- Female

♦ **YOUR BIRTH DATE** \_\_\_/\_\_\_/\_\_\_

♦ **PARTNER'S BIRTH DATE** \_\_\_/\_\_\_/\_\_\_

♦ **RACIAL BACKGROUND**

- African American / African / Black
- Asian / Indian
- Caucasian
- Native American / Alaska Native
- Pacific Islander
- More than one race
- Other \_\_\_\_\_

♦ **PARTNER'S RACIAL BACKGROUND**

- African American / African / Black
- Asian / Indian
- Caucasian
- Native American / Alaska Native
- Pacific Islander
- More than one race
- Other \_\_\_\_\_

♦ **ETHNICITY**

- Hispanic            Not Hispanic

♦ **PARTNER'S ETHNICITY**

- Hispanic            Not Hispanic

♦ **YOUR EDUCATION**

- Did not finish high school
- High school graduate/GED
- Completed trade school
- Some college
- Associates Degree
- Bachelor's degree
- Some graduate school
- Masters degree
- Doctoral degree (PhD, MD, JD, EdD, etc)

♦ **PARTNER'S EDUCATION**

- Did not finish high school
- High school graduate/GED
- Completed trade school
- Some college
- Associates Degree
- Bachelor's degree
- Some graduate school
- Masters degree
- Doctoral degree (PhD, MD, JD, EdD, etc)

♦ **YOUR OCCUPATION**

\_\_\_\_\_

♦ **PARTNER'S OCCUPATION**

\_\_\_\_\_

♦ **DURING THE LAST MONTH, WHAT WAS YOUR LEVEL OF FUNCTION AT WORK?**

Working full-time at a job	School/college full-time	Unemployed but able to work
Working full-time running household	School/college part-time	Unable to work
Working part-time	Doing volunteer work	Other _____

♦ **YOUR CURRENT LIVING SITUATION**

Living with your husband	Living with your family of origin (parents, etc)
Living with your partner / significant other	Living in a group home
Living as a single parent with your child(ren)	Homeless
Living on your own (alone or with roommate)	Other (describe) _____

## Medical History

♦ **CURRENT WEIGHT** (lbs) \_\_\_\_\_ ♦ **YOUR PRE-PREGNANCY WEIGHT** (lbs) \_\_\_\_\_

♦ **YOUR HEIGHT** (ft., in.) \_\_\_\_\_

♦ **DO YOU HAVE ANY MEDICATION ALLERGIES?** YES NO

Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Medication: _____	Reaction: _____

♦ **PAST OR CURRENT MEDICAL PROBLEMS**

<u><i>Autoimmune</i></u> Lupus Multiple Sclerosis Rheumatoid Arthritis Sjogren's Syndrome	<u><i>Cardiovascular</i></u> Anemia (chronic) Heart Disease Hypertension Phlebitis	<u><i>Endocrine</i></u> Diabetes Thyroid Disease	<u><i>Gastrointestinal</i></u> Crohn's GERD/Reflux Irritable Bowel Ulcerative Colitis
<u><i>OB/GYN</i></u> Abnormal Pap Endometriosis Preeclampsia/HELLP PCOS Pelvic Inflamm. PMS Rh Disease	<u><i>Infection</i></u> Chicken Pox Group B Strep Hepatitis Herpes HIV/AIDS Tuberculosis UTI (chronic)	<u><i>Neurological</i></u> Epilepsy/Seizures Migraines	<u><i>Other</i></u> Asthma Cancer Kidney Disease Other _____

## Genetic History

Genetic Illness	Family History	Your Genetic Test Results
Cystic Fibrosis	YES NO	Normal Abnormal NOT TESTED
Down Syndrome	YES NO	Normal Abnormal NOT TESTED
Hemophilia	YES NO	Normal Abnormal NOT TESTED
Huntington's Disease	YES NO	Normal Abnormal NOT TESTED
Muscular Dystrophy	YES NO	Normal Abnormal NOT TESTED
Neural Tube Defect (spina bifida)	YES NO	Normal Abnormal NOT TESTED
Sickle Cell Disease	YES NO	Normal Abnormal NOT TESTED
Tay Sachs	YES NO	Normal Abnormal NOT TESTED
Thalassemia, Alpha	YES NO	Normal Abnormal NOT TESTED
Thalassemia, Beta	YES NO	Normal Abnormal NOT TESTED
OTHER ( _____ )	YES NO	Normal Abnormal NOT TESTED

## Gynecological History

♦ **YOUR OB NAME / GROUP PRACTICE / ADDRESS / PHONE**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

♦ **HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL PERIOD?** \_\_\_\_\_

♦ **HOW MUCH PAIN DO YOU USUALLY HAVE WITH YOUR PERIODS?**

No Pain	Moderate cramps, medication usually needed
Mild cramps or infrequent pain (seldom needs meds)	Severe cramps, medication and bed rest needed

♦ **HOW REGULAR IS YOUR MENSTRUAL CYCLE?**

Regular \_\_\_\_\_ (number of days per cycle)                      Irregular

♦ **HAVE YOUR PERIODS EVER STOPPED TEMPORARILY?**    YES                      NO

If yes, mark which event caused your periods to stop and how long:

Sudden weight loss	Unexplained
Low body fat	Other _____
Chemotherapy or radiation treatment	
Hormonal Medication [Lupron (Leuprolide), Danocrine (Danzol), Synarel (Nafareline), Depo-provera]	

## Obstetrical History

♦ **HOW MANY TIMES HAVE YOU BEEN PREGNANT?** (including current pregnancy) . . . . . \_\_\_\_\_

♦ **HOW MANY FULL-TERM DELIVERIES?** (≥ 37 completed weeks) . . . . . \_\_\_\_\_

♦ **HOW MANY PRETERM DELIVERIES?** (≥ 20 TO < 37 completed weeks) . . . . . \_\_\_\_\_

♦ **HOW MANY MISCARRIAGES?** (pregnancy loss before 20 completed weeks) . . . . . \_\_\_\_\_

♦ **HOW MANY ABORTIONS HAVE YOU HAD?** . . . . . \_\_\_\_\_

♦ **HOW MANY LIVING CHILDREN DO YOU HAVE?** . . . . . \_\_\_\_\_

If one of your children has died, please explain the circumstances:

\_\_\_\_\_

♦ **HOW MANY MULTIPLE GESTATIONS AND BIRTHS HAVE YOU HAD?** . . . . . \_\_\_\_\_

PAST PREGNANCIES								
Please include pregnancies that ended with miscarriage, stillbirth, tubal pregnancy, etc.								
Date of Birth	Name of Child	Gender	Weeks	Wt	Length	Delivery Type	Anesthesia	Pregnancy/Delivery Complications

**Delivery Type:** Vaginal, C/S, Forceps, Vacuum    **Anesthesia:** Epidural, Local, General, Demerol    **Complications:** Diabetes, Bleeding, Hypertension



## Psychiatric History

♦ **HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISORDERS?**

Mood Disorders	Psychotic Disorders
Major Depression	Schizophrenia
Postpartum Depression	Schizoaffective Disorder
Dysthymic Disorder	Any Other Psychotic Disorder
PMS / Premenstrual Depression	Eating Disorders
Bipolar Disorder / Manic Depression	Anorexia Nervosa
Anxiety Disorders	Bulimia Nervosa
Generalized Anxiety Disorder	Any Other Eating Disorder
Panic Disorder	Substance Use Disorders
Obsessive Compulsive Disorder	Alcohol Abuse or Dependence
Social Anxiety Disorder	Cocaine Abuse or Dependence
Posttraumatic Stress Disorder	Opiate Abuse or Dependence
Any Other Anxiety Disorder	Any Other Substance Abuse Disorder
Personality Disorders	Other Disorders
Antisocial Personality Disorder	Attention Deficit Hyperactivity Disorder
Borderline Personality Disorder	Migraine Headaches
Any Other Personality Disorder	Seizure Disorder / Epilepsy
	Other, Please Specify _____

♦ **YOUR CURRENT PSYCHIATRIST'S NAME / ADDRESS / PHONE**

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♦ **YOUR CURRENT PSYCHOTHERAPIST'S/COUNSELOR'S NAME / ADDRESS / PHONE**

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♦ **PREVIOUS SUICIDE ATTEMPTS?** LIST NUMBER OF TIMES, METHODS, DATES:

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♦ **PREVIOUS SELF-INJURY (E.G. CUTTING)?** LIST NUMBER OF TIMES, DATES:

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♦ **PREVIOUS HOMICIDE OR VIOLENCE (INCLUDING CHILDREN)?**

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♦ **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS? WHERE AND WHEN?**

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♦ **WHAT TYPES OF PSYCHOTHERAPY HAVE YOU PREVIOUSLY HAD?**

- |                                    |                 |                       |
|------------------------------------|-----------------|-----------------------|
| CBT (Cognitive Behavioral Therapy) | Couples Therapy | Psychodynamic Therapy |
| DBT (Dialectical Behavior Therapy) | Family Therapy  | Supportive Therapy    |
| Other _____                        |                 |                       |

**♦ WHAT PSYCHIATRIC MEDICINES HAVE YOU TAKEN IN THE PAST? WHEN?**

Medication	Year(s) Taken 19__ to 20__	Medication	Year(s) Taken 19__ to 20__
<b>Antidepressants</b>		<b>Anti-Anxiety Medications</b>	
Anafranil (clomipramine)		Atarax / Vistaril (hydroxyzine)	
Celexa (citalopram)		Ativan (lorazepam)	
Cymbalta (duloxetine)		Buspar (buspirone)	
Effexor (venlafaxine)		Klonopin (clonazepam)	
Elavil (amitriptyline)		Librium (chlordiazepoxide)	
Lexapro (escitalopram)		Valium (diazepam)	
Luvox (fluvoxamine)		Xanax (alprazolam)	
Pamelor (nortriptyline)		Other Anti-Anxiety (Name _____)	
		<b>Mood Stabilizers / Anti-Epilepsy Drugs</b>	
Paxil (paroxetine)		Depakote (valproate)	
Pristiq (desvenlafaxine)		Dilantin (phenytoin)	
Prozac / Sarafem (fluoxetine)		Eskalith / Lithobid (lithium)	
Remeron (mirtazapine)		Keppra (levetiracetam)	
Serzone (nefazodone)		Lamictal (lamotrigine)	
Viibryd (vilazodone)		Neurontin (gabapentin)	
Wellbutrin / Zyban (bupropion)		Tegretol / Carbatrol / Equetro (carbamazepine)	
Zoloft (sertraline)		Topamax (topiramate)	
Other Antidepressant (Name _____)		Trileptal (oxcarbazepine)	
<b>Antipsychotics</b>		<b>Stimulants / ADHD Medications</b>	
Abilify (aripiprazole)		Other Mood Stabilizer / AED (Name _____)	
Fanapt (iloperidone)		Adderall (amphetamine mixture)	
Geodon (ziprasidone)		Cylert (pemoline)	
Haldol (haloperidol)		Dexedrine (dextroamphetamine)	
Invega (paliperidone)		Focalin (dexmethylphenidate)	
Latuda (lurasidone)		Intuniv / Tenex (guanfacine)	
Risperdal (risperidone)		Meridia (sibutramine)	
Saphris (asenapine)		Provigil (modafinil)	
Seroquel (quetiapine)		Ritalin / Concerta / Metadate (methylphenidate)	
Zyprexa (olanzapine)		Strattera (atomoxetine)	
Other Antipsychotic (Name _____)		Vyvanse (lisdexamfetamine)	
		Other ADHD Medication (Name _____)	
<b>Sleep Medications</b>			
Ambien (zolpidem)		Rozerem (ramelteon)	
Desyrel (trazodone)		Sinequan (doxepin)	
Lunesta (eszopiclone)		Sonata (zaleplon)	
Melatonin		Unisom (doxylamine)	
ProSom (estazolam)		Other Sleep Medication (Name _____)	
Restoril (temazepam)			

**♦ WHICH TREATMENT OR COMBINATION OF TREATMENTS HAS WORKED BEST FOR YOU?**

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## Drug & Alcohol History

Drug Name	Age of 1 <sup>st</sup> Use	Current Amt/Freq	Peak Amt/Freq	Last Use
MARIJUANA				
COCAINE				
ALCOHOL				
SEDATIVES <small>BARBITURATES, BENZODIAZEPINES</small>				
HALLUCINOGENS <small>LSD, PCP, ACID</small>				
AMPHETAMINES <small>UPPERS, SPEED, CRANK, ICE, 8-BALLS</small>				
NARCOTICS <small>HEROIN, OXYCODONE, ETC.</small>				
INHALANTS <small>GASOLINE, GLUE, PAINT THINNER, WHITE-OUT, HUFFING</small>				

♦ **TREATMENT FOR DRUG OR ALCOHOL ABUSE:** LIST LOCATIONS, DATES OF TREATMENT, DURATION.

INPATIENT DETOX \_\_\_\_\_

LONG-TERM RESIDENTIAL \_\_\_\_\_

OUTPATIENT \_\_\_\_\_

♦ **LEGAL PROBLEMS RELATED TO DRUG/ALCOHOL USE:** \_\_\_\_\_

♦ **WITHDRAWAL SYMPTOMS / MEDICAL PROBLEMS FROM DRUG/ALCOHOL USE:** \_\_\_\_\_

## Family Psychiatric History

♦ **HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:**

MAJOR DEPRESSION	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
POSTPARTUM DEPRESSION	NONE	MOTHER		SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
BIPOLAR DISORDER / MANIC DEPRESSION	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
GENERALIZED ANXIETY DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
PANIC DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
OBSESSIVE COMPULSIVE DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
SOCIAL ANXIETY DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
POSTTRAUMATIC STRESS DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
SCHIZOPHRENIA	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
SCHIZOAFFECTIVE DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
ANOREXIA / BULIMIA NERVOSA	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
ALCOHOL ABUSE / DEPENDENCE	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
ANY SUBSTANCE ABUSE / DEPENDENCE	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
ATTENTION DEFICIT/HYPERACTIVITY D/O	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
BORDERLINE PERSONALITY DISORDER	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER
OTHER MENTAL ILLNESS (_____)	NONE	MOTHER	FATHER	SIBLING: BRO / SIS	CHILD: SON / DAU	GRAND- PARENT	OTHER

