IRONWOOD Family Practice
920 Ironwood Drive, Suite 101 Coeur d'Alene, Id 83814 (208) 667-4557

Please circle name of primary care provider

Brittany C. Burns, MD
Timothy F. Burns, MD
David L. Chambers, MD
Donald R. Chisholm, MD
Geoffrey T. Emry, MD
Hollie E. Mills, MD
Audrey Buckland, PA-C
Jessica B. Capaul, ARNP

NEW OB PATIENT INFORMATION

Full Legal Name: _____ Date of Birth: ____/____/____
Last First MI

Contact Information:
Husband/Partner: _____ Phone #: (____) _____

Father of Baby: _____ Phone #: (____) _____
[ ] Same as Husband/Partner

Emergency Contact: _____ Phone #: (____) _____
[ ] Same as Husband/Partner

Pregnancy Type: [ ] Single [ ] Twins [ ] Triplets [ ] Quadruplets

Menstrual History:
Last Menstrual Period Date: _____
Last Menstrual Period Description: [ ] Normal Amount/Duration [ ] Abnormal Amount/Duration
Menses Monthly: [ ] Yes [ ] No Menses Frequency: Every _____ Days
On Birth Control at Conception: [ ] Yes [ ] No Age of Menarche: _____ Years hCG+ Date: _____

Pre-Pregnancy Vital Signs:
Blood Pressure: _____/_____ mmHg Weight: _____ lbs.

PATIENT MEDICAL HISTORY:

Diabetes: [ ] YES [ ] NO
Hypertension: [ ] YES [ ] NO
Heart Disease: [ ] YES [ ] NO
Autoimmune Disorder: [ ] YES [ ] NO
Kidney Disease/UTI: [ ] YES [ ] NO
Neurological/Epilepsy: [ ] YES [ ] NO
Psychiatric: [ ]YES [ ] NO
Depression/Postpartum Depression: [ ] YES [ ] NO
Hepatitis/Liver Disease: [ ] YES [ ] NO
Varicosities/Phlebitis: [ ] YES [ ] NO
Thyroid Dysfunction: [ ] YES [ ] NO
Trauma/Violence: [ ] YES [ ] NO
Tobacco: [ ] YES [ ] NO
Alcohol: [ ] YES [ ] NO
Illicit/Recreational Drugs: [ ] YES [ ] NO
D (Rh) Sensitized: [ ] YES [ ] NO
Pulmonary (TB. Asthma): [ ] YES [ ] NO
Seasonal Allergies: [ ] YES [ ] NO
Breast: [ ] YES [ ] NO
Gynecological Surgery: [ ] YES [ ] NO
Drug/Latex Allergies/Reactions: [ ] YES [ ] NO
Operations/Hospitalizations: [ ] YES [ ] NO
Anesthetic Complications: [ ] YES [ ] NO
History of Abnormal Pap: [ ] YES [ ] NO
Uterine Anomaly/DES: [ ] YES [ ] NO
Infertility: [ ] YES [ ] NO
ART Treatment: [ ] YES [ ] NO
Relevant Family History: [ ] YES [ ] NO
Other: [ ] YES [ ] NO Explain: _____
History of Blood Transfusion: [ ] YES [ ] NO

PATIENT RISK ASSESSMENT:

Live with someone with TB or Exposed to TB: [ ] YES [ ] NO
Patient or Partner has history of Genital Herpes: [ ] YES [ ] NO
Rash or Viral Illness since last menstrual period: [ ] YES [ ] NO
Hepatitis B, C: [ ] YES [ ] NO
History of STD: [ ] YES [ ] NO
History of Gonorrhea: [ ] YES [ ] NO
History of Chlamydia: [ ] YES [ ] NO
History of HPV: [ ] YES [ ] NO
History of HIV: [ ] YES [ ] NO
History of Syphilis: [ ] YES [ ] NO
Other: [ ] YES [ ] NO Explain: _____
Late to prenatal care: [ ] YES [ ] NO
Advanced Maternal Age: [ ] YES [ ] NO
Rh Negative: [ ] YES [ ] NO
History of MRSA: [ ] YES [ ] NO

PAST PREGNANCY:

Total Pregnancies: _____
Full Term: _____
Premature: _____
Abortion Induced: _____
Abortion Spontaneous: _____
Ectopic: _____
Living: _____
Multiple Births: _____