Atlantic Health System
Atlantic Medical Group

# Women's Health Intake Questionnaire

Date of call/Walk in (circle one): _____ Time: _____
Patient Name: _____ DOB: _____ AGE: _____
Address: _____
City/State: _____ Zip Code_____ Phone #: _____
Email: _____ LMP:_____ Due date: _____
Primary Language: _____ 8 weeks of pregnancy as of: _____
Emergency Contact name/ Phone #: _____
**INSURANCE INFORMATION**: Company: _____ ID #: _____
Where was your pregnancy test completed?_____ Is this an IVF pregnancy? Y/N
Transferring/ IVF pregnancy? [ ] No [ ] Yes
If Yes, Record request obtained (Even if records have been provided) [ ] YES
From: _____ Reason for transfer request: _____
Did you go to ER related to this pregnancy? [ ] Yes [ ] No If YES, which ER: _____
Is this your 1st pregnancy? [ ] yes [ ] no/ how many other pregnancies? _____
Is this a TWIN pregnancy? [ ] yes [ ] no
History of pregnancy loss after 14 weeks [ ] no [ ] yes/ how many losses? _____
At how many weeks? _____
History of PRETERM births? [ ] no [ ] yes If yes, how many? _____
How many C-sections? _____ At how many weeks? _____
Was early/preterm delivery related to any of the following:
[ ] preterm labor [ ] rupture of membranes [ ] doctor decided to deliver early (reason) _____
Do you have a child with any birth defects? [ ] no [ ] yes What type? _____

Do YOU have any medical problems, such as:
[ ] Diabetes/ [ ] Diabetes in pregnancy ~ are you taking ? [ ] insulin [ ] pills
[ ] Have you had any weight loss surgery? If yes, which surgery?/when? _____
[ ] Heart conditions [ ] Thyroid problems [ ] High blood pressure
[ ] Seizures [ ] genetic conditions [ ] history of blood clots/stroke
[ ] Lupus [ ] Kidney disease [ ] cancer
[ ] drug/alcohol problems [ ] mental health conditions [ ] other: _____
Have you taken/ do you current take ANY medication for ANY medical problems? [ ] No [ ]YES
If yes, list medications : _____
_____
Do have any conditions that your feel need urgent attention [ ] No [ ] yes If yes: specify:_____
_____
Clinical assistant completing questionnaire : _____ Date:_____
APN/RN signature: _____ Date: _____
APN/RN comments: _____
_____
[ ] awaiting records [ ] record review complete date: _____ Signature: _____

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INTAKE Appointment Date: _____ Time: _____

Records requested- specify date(s) and what was requested with any additional requests:
Initial request: _____
2nd request: _____ for _____
3rd request: _____ for _____

OTHER: _____
NOTES: _____
_____
_____

Records Received (specify dates/initial) - Specify on front of form when review complete and appointment assignment can be made:
Date: _____ Name/Initial: _____
Date:_____ Name/ Initial: _____
Date: _____ Name/Initial: _____

**Records reviewed**:
Date: _____ by RN/APN: _____
Missing documents: _____
Date: _____ by RN/APN: _____
Missing documents: _____
Date: _____ by RN/APN: _____
Missing documents: _____

**OKAY to schedule with MD [ ] AMENO [ ] IPV schedule for RN Intake Yes [ ] No [ ]**

**Refer to: [ ] clinic [ ] High risk**
Patient contact/follow- up Date, reason, outcome and initials/signature:
_____
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