URMC MIDWIFERY GROUP

— INTAKE FORM

UR MEDICINE

DEMOGRAPHICS & REASON FOR VISIT

Preferred Name **Pronouns:** **Gender:** **Sex Assigned at Birth**

#1 Reason for Today's Visit: _____

Other Concerns:

Medications:

Vitamins/ Supplements:

SOCIAL HISTORY

Who do you live with? **Partner's Name & Age:**

Occupation: **Hobbies:**

Do you want to discuss any of the following (please circle)

Transportation Financial Concerns Food Clothing/Supplies Housing
Insurance Childcare Relationship Issues

HEALTH PROMOTION

What types of foods do you typically eat:

Do you currently or have you in the past struggled with an eating disorder? YES/NO

Type of Exercise: **Amount of exercise/week:**

Hours of Sleep/night

Ways you manage stress:

THANK YOU FOR YOUR INFORMATION

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GYNECOLOGIC HISTORY

Age of first period:

Are your periods: regular irregular

How often do they come?

How many days of bleeding?

When was the 1st day of your last period? _____

Have you had unprotected sex since your last period? YES/NO

Do you use condoms? YES/NO **If so, what % of the time?** 25% 50% 75% 100%

Would you like sexually transmitted infection (STI) testing today? YES/NO

What birth control are you using, if any?

Do you have any of the following vaginal concerns today?

☐ Itching ☐ Odor ☐ Irritation ☐ Change in Discharge ☐ Other _____

Do you have any of the following sexual health concerns today?

☐ Pain with Sex ☐ Bleeding ☐ Difficulty with Orgasm ☐ Other _____

Have you had the HPV vaccine? YES/NO/UNSURE

Have you ever had an abnormal pap smear (Cervical Cancer Screening)? YES/NO/UNSURE

Do you have a history of sexual assault or trauma that you would like us to be aware of ? YES/NO

If so, would you be open to discussing it at today's visit? YES/NO

FAMILY HISTORY

Does anyone in your family have a history of:

☐ Breast Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Colon Cancer ☐ Other Cancer ☐ Easy bleeding or bruising

☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure ☐ Osteoporosis ☐ Genetic Abnormalities

Other Family History/Details:

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HEALTHCARE SUPPORT TEAM

Primary Care Provider Year of Last Visit

Dentist Year of Last Visit

Eye Doctor Year of Last Visit

Chiropractor Year of Last Visit

Mental Health Support Year of Last Visit

Other Year of Last Visit

Other:

OBSTETRIC HISTORY

Past Pregnancies (please include all miscarriages, abortions, and ectopic pregnancies)

	Date	Place	Weeks pregnant at delivery	Type of Birth	Sex & Weight of Baby	Complications with Birth or Pregnancy
1.				vaginal c-section		
2.				vaginal c-section		
3.				vaginal c-section		
4.				vaginal c-section		
5.				vaginal c-section		
6.				vaginal c-section		
7.				vaginal c-section		
8.				vaginal c-section		
9.				vaginal c-section		

Have you had any of the following during your past pregnancies or births? (Please check)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Anemia
- ☐ Abnormally Heavy Bleeding after birth
- ☐ Problems with Placenta
- ☐ Vacuum Birth
- ☐ Forcep Birth
- ☐ Shoulder Dystocia
- ☐ Trouble with Epidural/Spinal
- ☐ 3rd/4th degree tear
- ☐ Induction
- ☐ Other

Is there anything else you would like us to know about your past pregnancies/births?

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SUBSTANCE USE

	Currently using?	Used in Past?	Last Used
Cigarettes	☐	☐	
Vaping	☐	☐	
Chewing Tobacco	☐	☐	
Other	☐	☐	

	Currently using?	Used in Past?	Last Used
Marijuana/THC	☐	☐	
Cocaine	☐	☐	
Heroin	☐	☐	

SAFETY ASSESSMENT

Have you ever been abused, hurt or threatened by anyone, including your parents?	YES/NO
Does your partner ever prevent you from going where you want, when you want?	YES/NO
Has your partner ever called you names or put you down?	YES/NO
Are you afraid of your partner?	YES/NO
Has your partner ever threatened to hit you or throw things at you?	YES/NO
Has your partner ever hit, slapped, kicked, punched, or threatened you with a weapon?	YES/NO
Have you ever had to see a doctor after your partner hit you?	YES/NO
Do you know who you can turn to if your partner was hurting you?	YES/NO

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MENTAL HEALTH SCREENING

PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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MENTAL HEALTH SCREENING

General Anxiety Disorder -7 (GAD-7)

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

 Published in: Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med 2006; 166:1092.

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ALCOHOL USE SCREENING

Alcohol Screening Questionnaire (AUDIT)

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

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