Medical Assessment
Intake Form for Pregnant and Parenting Teens

Name: _____ Birth Date: _____
Grade: _____ School ID #_____Cell #_____
Home Address: _____
Email: _____
Parents/ Guardian: _____
_____
Parent/ Guardian Home Phone: _____ Work: _____
Cell: _____
Race /Ethnicity (Please choose all that apply)

_____American Indian or Alaskan Native
_____Asian Indian
_____Black, African – American
_____Filipino
_____Guamanian or Chamorro
_____Hispanic/Latino/Spanish
_____Japanese
_____Other Race: _____
_____ Korean
_____Native Hawaiian
_____Other Asian
_____Other Pacific Islander
_____ Samoan
_____ Vietnamese
_____ White

MEDICAL PROVIDERS:

Primary Care Provider	Address	Phone Number	Date of Last Appointment	Next Appointment
OG/GYN Provider	Address	Phone Number	Date of Last Appointment	Next Appointment
Dental Provider	Address	Phone Number	Date of Last Appointment	Next Appointment
Other Provider (s)	Address	Phone Number	Date of Last Appointment	Next Appointment

Do you receive any special medical services? (physical therapy, chiropractic care, speech therapy) **Yes** **No**
If yes, explain:

Client Name: _____

ALLERGIES: □No Known Allergies or List Below

Medication/Food/Substance	Reaction

HEALTH HISTORY:

Have you ever been diagnosed with any of the following?

Diagnosis/Condition	Yes	No	Currently	In the past (age)
Asthma				
Anemia				
Cancer				
Diabetes				
High blood pressure				
Heart disease				
Heart murmur				
Seizures				
Urinary Tract Infection				
Bronchitis				
Pneumonia				
Bleeding tendencies				
Liver disease (explain)				
Sickle cell trait/disease				
Kidney disease (explain)				
Gastrointestinal disorders (ulcers, GERD, Chrohn's disease)				
Eczema/Psoriasis				
Eye disorders/disease (glaucoma)				
Bone disorders (explain)				
STI (Chlamydia, gonorrhea, genital warts, herpes)				
Other (explain)				

Do you smoke cigarettes or use any tobacco products? □**Yes** □**No**

If yes, How much per day? _____

If former smoker, when did you quit? _____

Are you exposed to second-hand smoke? **Yes** **No**

Client Name: _____

MEDICATIONS: Complete below or enter NA

Name	Dose	How often?	Date Started	Date Stopped	Reason Stopped

HOSPITALIZATIONS/SURGERIES: Complete below or enter NA.

(Not including Emergency Room visits)

Date	Reason	Outcome

DIETARY AND EXERCISE HISTORY:

Typical diet consists of: (choose all that apply)

fruits vegetables protein (meat, peanut butter, nuts, eggs) dairy whole grain/wheat

candy snacks (chips, cookies, cakes) other (specify)_____ _____ _____

How often do you drink water? daily 3-4 days/ week 1-2 days/ week never

How often do you drink coffee/tea? daily 3-4 days/week 1-2 days /week never

How often do you drink soda? daily 3-4 days/week 1-2 days/week never

How often do you eat snacks? (chips, cookies, cakes) daily 3-4 days/ week 1-2 days/ week never

Number of meals per day_____ Skipped meals per day_____

Cravings: _____

No. of Hours of sleep per night _____

Type of exercise:_____ Frequency: _____

Client Name: _____

REPRODUCTIVE HEALTH HISTORY:

LMP (last menstrual period):_____

Do you experience any of the following with your menstrual cycle?

□ heavy bleeding □ excessive cramping □ lasting more than 7 days □ occurring less than 21-28 days each month

Explain: _____

Do you protect yourself against STDs? □**Yes** □**No**

How often? □ always □ most of the time □ sometimes □ seldom

Have you ever had STD testing? □**Yes** □**No** HIV testing? □**Yes** □**No**

Have you ever had cervical cancer screening (pap smear)? □**Yes** □**No** Date of last exam: _____

Any medical concerns?:_____

_____

_____

PRENATAL HISTORY: □

Pregnancy trimester_____ # of weeks_____ expected date of delivery_____

Feelings about pregnancy_____

Is father involved? _____

Parents'feelings/involvement_____

Health insurance_____ WIC _____Food Stamps_____ Other_____

Type of housing_____

Adequate plumbing, electricity, stove, refrigerator? _____

Safety concerns? _____

When did prenatal doctor's visits begin?_____

Date of last visit_____ Date of next visit _____

Prepregnancy weight _____ Current weight _____

Has the doctor identified any problems with this pregnancy? Yes No

Describe: _____

What screening/tests have you had? _____

Any abnormal results? _____

Any screening/tests scheduled? _____

Have you experienced any of the following during this pregnancy?

_____Swelling of hands or feet
_____Nausea/vomiting
_____Hemorrhoids
_____Vaginal bleeding
_____Backaches
_____Other
_____Constipation or diarrhea
_____ Leg cramps
_____Heartburn
_____Headaches
_____Contractions

Client Name: _____

Who will be present during labor and delivery? _____
Who will be with you when you arrive home with the baby? _____
Interested in Lamaze classes? _____
Infant feeding plans: Breastfeed? _____Formula? _____
Do you take the following?
_____prenatal vitamins _____iron pills _____ other supplements
Any dental problems? _____ Date of last check up _____
Exposure to chemicals? _____ (glue, bleach, ammonia, pesticides)

POSTPARTUM/OBSTETRICAL INFORMATION:

Date of delivery _____ type of delivery _____
Delivery facility _____ # of days hospitalized _____
Weeks postpartum this visit _____
Total pregnancy weight _____ Current weight _____
Have you had your postpartum checkup? Yes No
Health concerns: _____
Are you breast feeding? Yes No Problems? _____
Using birth control after delivery? _____ Method: _____
Are you comfortable in your relationship with your baby? _____
Any concerns? _____
Are you feeling depressed/sad since delivery? _____
How have family members adjusted to new baby? _____
How is the baby's father involved?_____