Uvalde Family Practice Assn.
1800 Garner Field Road • Uvalde, TX 78801 • PH (830) 278-4453 • FAX (830) 278-3427

New OB Patient Application

Please fill all the information completely, return back to UFPA or fax to 830-278-3427; and please attach a copy of your current insurance card (front & back)

Primary Care Physician: Cherie Hauptmeier, D.O. Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Primary Phone Number: _____ ☐ Home ☐ Cell Relationship Status: ☐ Single ☐ Married/Partnered

Father of Baby: _____ Father's Phone Number: _____

Previous Doctor: _____

Please list any prescriptions, over the counter medications, supplements and vitamins you are currently taking:

_____

Please list any known allergies and type of reaction: _____

Health History

	YES	NO		YES	NO		YES	NO
Abnormal Pap			Heart Problems			Mental Health Disorders		
Anemia			HIV/AIDS			Postpartum Depression		
Anesthetic Complications			Hypertension			Seizures		
Asthma			Infertility			Sickle-Cell Anemia		
Blood disorder			Kidney Disease			Thyroid Disease		
Breast Problems			Liver Disease			Trauma/Violence		
Diabetes (Mellitus or Gestational)			Blood Clots (Varicositis/Phlebitis)			Blood Type (Rh) incompatibility		
Do you authorize the administration of blood products in the event of a medical emergency? If *No*, explain:						Lupus		
Surgeries			If *Yes*, list surgeries & dates:					
Hospitalizations			If *Yes,* what for?					

Infection History

Do you:	YES	NO		YES	NO
Live with anyone who has tuberculosis (TB)/have been exposed to TB?			Have Hepatitis B or C?		
Have a rash or viral illness since your last menstrual period?			Have a history of STIs, including Gonorrhea, Chlamydia, HPV, Syphilis, or others?		
Have a history of genital herpes (or your partner)?					

Other conditions not mentioned above: _____

Family History

Have you or any of your blood relatives had any of the following illnesses? Please include parents, grandparents, siblings or children in either family. Note the family member's age at onset, their relation to you, and whether they are related **Maternally (M)** or **Paternally (P)** to you.

	YES	NO	Who, M/P		YES	NO	Who, M/P
Anemia				Infertility			
Asthma				Kidney Disease			
Bleeding Problems				Liver Disease			
Cancer				Lupus			
Diabetes				Mental Health Disorders			
Heart Disease				Preeclampsia			
Premature CHD				Pre-term Labor			
Hepatitis				Seizures			
HIV/AIDS				Thyroid Disease			
Hypertension				Other			

Genetic History

Do you, the baby's father, or anyone in **either family** have a history of the following illnesses? Please include parents, Grandparents, siblings or children in either family.

	YES	NO	Who, M/P		YES	NO	Who, M/P
Age 35 or older at estimated date of delivery				Autism and/or Mental Retardation (If *YES*, was person tested for Fragile X?			
Thalassemia				Cystic Fibrosis			
Neural Tube Defects				Huntington's Chorea			
Congenital Heart Defect				Other Inherited Genetic or Chromosomal Disorder			
Down Syndrome				Maternal Metabolic Disorder			
Tay-Sachs				Recurrent Pregnancy Loss			
Hemophilia				Muscular Dystrophy			
Canavan Disease				Medications/Drugs Taken Since Last Menstrual Period			
Familial Dysautonomia				You or baby's father has a child with birth defects not listed above			
Sickle Cell Disease/Trait				Any other Genetic Conditions not listed			

Social History / Safety

Do you drink alcohol? ☐ NO ☐ YES If *YES*, please list how many drinks you typically consume in a week:
Glasses of wine: _____ Beer (12 ounces): _____ Shots: _____ Drinks with 0.5 oz. of alcohol _____

Do you currently use drugs (illegal)? ☐ NO ☐ YES If *YES*, please list: _____

Do you currently smoke tobacco? ☐ NO ☐ YES If *YES,* how many packs per day? _____

Have you every regularly smoked tobacco? ☐ NO ☐ YES Year you quit smoking: _____

Do you currently use smokeless tobacco? ☐ NO ☐ YES

Are you regularly around cats or have cats in your home? ☐ NO ☐ YES

Are you a victim of domestic violence? ☐ NO ☐ YES

Have you experienced any physical/sexual/mental abuse? ☐ NO ☐ YES

Obstetric History

History of Menses: Do you have a regular menstrual cycle? ☐ YES ☐ NO – Please explain: _____
Date of last menstrual period (mm/dd/yyyy): _____
Was this last period normal? ☐ YES ☐ NO – Please explain: _____
How much time did you usually have from the start of one period to the start of another? _____
How many periods did you have in the last year? _____
What was the longest time between periods in the last year? _____
Total Pregnancies: _____ Full Term (37-40 weeks): _____ Premature (less than 37 weeks): _____
Miscarriages: _____ Abortions: _____ Ectopic: _____ Multiples: _____ Living: _____

Pregnancy Details – Please fill out as completely as possible for all pregnancies

	First	Second	Third	Fourth	Fifth
Date of Delivery					
Number of Weeks Pregnant at Delivery					
Vaginal or C-Section?					
Length (in hours) of Labor					
Birth Weight					
Sex & Name of Baby					
Anesthesia Used, if Any?					
Preterm Labor					
Currently Living or Deceased?					
Location of Delivery					
Delivering Doctor/CNM					
List Any Complications					

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Accepted: _____ Declined: _____ Physician Signature: _____ Date: _____ Date Notified: _____