Mills
Obstetrics & Gynecology

Postpartum Patient Intake Form

Patient name: _____ Date of birth: _____

Please give us a few details about your delivery:

a. Date of delivery: _____

b. Date of Discharge: _____

c. Did baby go to NICU: _____

d. Baby(s) Full Name: _____

e. Sex: _____ If male, did he have circumcision?_____

f. Weight:_____

g. Delivering Doctor: my doctor on call doctor, Name of on call doctor _____

h. Did you have an epidural?_____

i. Mode of delivery: vaginal Cesarean Forceps/ Vacuum

If vaginal delivery, did you have a third- or fourth-degree tear? NO YES Unsure

If Cesarean, was it a planned cesarean? NO YES

How are you feeding your baby? Nursing Pumping Formula

How long is your baby's longest stretch of sleep most nights? _____

Who is helping you with the baby? _____

Have you and your partner had intercourse? NO YES (used a condom) YES (didn't use a condom)

What are you planning to do for contraception? ____Pills ____ Vaginal Ring ____Implant

____ Shot ____ IUD (which one?) _____ ____ condoms or natural family planning

Sterilization: ____tubal ____vasectomy, if yes, is it already done? NO YES

____ Planning abstinence ____ Same sex relationship ____ undecided and need to talk about this today

Other concerns I would like to discuss today:

_____

_____

What medications are you currently taking?

_____

_____

Please select the answer that best describes how you have felt in the last 7 days:

I have been able to laugh and see the funny side of things

a. As much as I always could
b. Not quite so much now
c. Definitely not so much now
d. Not at all

I have looked forward with enjoyment to things

a. As much as I always could
b. Not quite so much now
c. Definitely not so much now
d. Not at all

I have blamed myself unnecessarily when things went wrong

a. No, never
b. Not very often
c. Yes, some of the time
d. Yes, most of the time

I have been anxious or worried for no good reason

a. No, never
b. Not very often
c. Yes, some of the time
d. Yes, most of the time

I have felt scared or panicky for no good reason

a. No, never
b. Not very often
c. Yes, some of the time
d. Yes, most of the time

Things have been getting to me

a. No, I have been coping well as ever
b. No. most of the time I have coped quite well
c. Yes, sometimes I haven't been able to cope at all
d. Yes, most of the time I haven't been able to cope at all

I have been so unhappy that I have had difficulty sleeping

a. No, never
b. Not very often
c. Yes, some of the time
d. Yes, most of the time

I have felt sad or miserable

a. No, never
b. Not very often
c. Yes, some of the time
d. Yes, most of the time

I have been so unhappy that I have been crying

a. No, not at all
b. Only occasionally
c. Yes, quite often
d. Yes, most of the time

The thought of harming myself has occurred to me

a. Never
b. Hardly ever
c. Sometimes
d. Yes, quite often

Patient Signature: _____ Date: _____

Review of Systems

Please circle any problems you are having: or ____ No complaints at this time

Constitutional: ____ No complaints

- Fever, fatigue, significant weight loss, ___lbs., significant weight gain, ___lbs.
- Additional info _____

Cardiovascular: ____ No complaints

- Chest pain, irregular heartbeat, difficulty breathing
- Additional info _____

Gastrointestinal: ____ No complaints

- Heartburn, difficulty swallowing, nausea, vomiting, abdominal pain, bowel movement changes, diarrhea, constipation, rectal bleeding
- Additional info _____

Genitourinary: ____ No complaints

- Blood in urine, abnormal bleeding, flank pain, trouble urinating, urinary frequency, urinary urgency, painful urination, frequent urination at night, incontinence, rash, lesion, discharge, vaginal odor, vaginal itching
- Additional info _____

Endocrine: ____ No complaints

- Thyroid disease, type 2 diabetes
- Additional info _____

Menstrual: ____ No complaints ____ Currently no period due to: _____

- Irregular timing, light flow, heavy flow, severe cramping, mood swings, irritability, tension/ anxiety, depression,
  breast pain/ tenderness, bloating, feeling out of control/ overwhelmed
- Additional info _____

Menopausal: ____ No complaints

- Hot flashes, night sweats, vaginal dryness, memory loss, difficulty concentrating
- Additional info _____

Sexual: ____ No complaints

- Decreased sex drive, painful intercourse, vaginal tightness, vaginal discomfort, bleeding w/ intercourse
- Additional info _____

Psych: ____ No complaints

- Depression, anxiety, alcoholism, sleep disturbances, not situational, chronic, not chronic
- Additional info _____

Breast: ____ No complaints

- Breast lump, breast mass, nipple discharge, skin changes, breast pain ___left ___right
- Additional info _____

Pain: ____ No complaints

- Chronic pain: neck, back, joint, other
- Additional info _____

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Today's Date: _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents, great aunts/uncles or great grandchildren

YOUR FAMILY'S Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	PANCREATIC, PROSTATE OR OTHER:							

☐ Y ☐ N Are you of Jewish descent? ☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain:

Risk Assessment Criteria (for office use only)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ *Personal* dx of breast cancer at any age
- ☐ Breast cancer diagnosed *under* the age of 50*
- ☐ Ovarian cancer dx at any age*
- ☐ Male breast cancer dx at any age*
- ☐ Metastatic prostate cancer dx at any age*
- ☐ Pancreatic cancer dx at any age*
- ☐ Two primary breast cancers in the same person, dx any age*
- ☐ Two relatives on the same side of the family with an HBOC** cancer, one being breast diagnosed *at* or *under* age 50
- ☐ Three or more relatives on the same side of the family with any of the following cancers dx at any age: breast, ovarian, pancreatic or aggressive prostate
- ☐ Triple negative breast cancer dx at or under the age of 60 (receptor status negative for ER, PR and HER2)*
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**

Lynch Syndrome

- ☐ *Personal* dx of colon or endometrial cancer before age 64
- ☐ 1 Colon or Endometrial cancer dx before age 50 in 1st° relative
- ☐ 2 or more Lynch assoc. cancers *** on the same side of the family, 1 being colon or endometrial dx *at* or *before* age 50*
- ☐ 3 or more relatives on the same side of the family dx with a Lynch syndrome associated cancer*** at any age*
- ☐ A previously identified hereditary cancer syndrome mutation in the family
- ☐ Personal hx of 10 or more cumulative pre-cancerous colon polyps

* In self, first or second degree family members
****HBOC** associated cancer includes: *breast, ovarian, pancreatic and aggressive prostate cancer*
*****Lynch**-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Family History Risk Assessment Review and Counseling

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Appointment: _____

Patient offered hereditary cancer testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED