

Lexington • Ob Gyn

Scheduling your Initial Obstetrical Appointment

In order for the office to appropriately schedule your initial obstetrical visit, you will be asked the following questions. Please review the questions below and have the answers ready. You may also fax this form to our office manager who will call you back to schedule your initial obstetrical appointment.

What is your name?	
What is your date of birth (MM/DD/YYYY) and age?	____/____/____ AGE:
Are you a New or Established patient?	<input type="checkbox"/> New <input type="checkbox"/> Established
What insurance plan do you have?	
What is your insurance ID# (sometimes called a policy or subscriber #)	
What are your telephone numbers?	Home: Work: Cell:
With which physician would you like to make your appointment with?	
Who referred you to our office?	
Have you seen another physician for this pregnancy?	<input type="checkbox"/> No <input type="checkbox"/> Yes, who?
Are you planning on delivering your baby with us?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many obstetrical visits did you have?	
What was the date of the first day of your last menstrual period (LMP)?	
How many times have you been pregnant (total number of times regardless of outcome)? Circle one	0 1 2 3 4 5 6 7 8 9 10
How many children have you delivered? Circle one	0 1 2 3 4 5 6 7 8 9 10
Have you previously had any of the following? If so, what type and how many?	<input type="checkbox"/> Miscarriages # of <input type="checkbox"/> Spontaneous Abortions # of <input type="checkbox"/> Termination of pregnancy # of <input type="checkbox"/> Ectopic pregnancy # of <input type="checkbox"/> Chemical pregnancy. # of
Did you become pregnant naturally?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you become pregnant by IVF?	<input type="checkbox"/> Yes <input type="checkbox"/> No What was the retrieval Date?
Did you become pregnant by IUI?	<input type="checkbox"/> Yes <input type="checkbox"/> No What was the insemination Date?
How many babies are you carrying?	1 2 3 4 5 6 7 8 9 10
Do you have any of the following risk factors?	<input type="checkbox"/> Diabetes <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> History of Gestational Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> History of Hypertension <input type="checkbox"/> Pre-term labor <input type="checkbox"/> History of Pre-term labor <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> History of Pre-esclampsia <input type="checkbox"/> Hyperemesis <input type="checkbox"/> History of Hyperemesis

Congratulations, you are now ready to schedule your initial obstetrical visit. Please call our office manager at (212) 686-8686 extension 308 or fax the completed sheet to (212) 686-1920 ATTN: Office manager.