Mountain View Hospital
Maternal Fetal Medicine

2321 Coronado St.
Idaho Falls, ID 83404
PHONE: 208.607.4326
FAX: 208.607.4327

PATIENT INFORMATION (Please Print)

How well do You Speak English? ❑ Very Well ❑ Well ❑ Not Well ❑ Not at All

Patient's Name: (LAST)_____(FIRST)_____(Middle)_____

Address:_____City, State, ZIP:_____

Phone:_____ Email:_____

AGE:_____ Date of Birth: _____/_____/_____

Date of Last Menstrual Period:_____/_____/_____

Emergency Contact Name:_____ Phone Number:_____

Relationship to Patient:_____

PRIMARY INSURANCE INFORMATION (Provide your insurance card to the front desk)

Name of Insured:_____Patient Relationship to Insured:_____

Insured Date of Birth:_____/_____/_____

Insurance Company:_____

Subscriber ID (Policy Number)_____ Group ID:_____

Effective Date:_____/_____/_____

Patient (or Responsible Party) Signature_____ **Date** ____/_____/_____

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Maternal Fetal Medicine Intake Questionnaire

(Please fill out completely)

Patient Name:_____Age:_____Date of Birth:____/____/____
1st day of last menstrual period:_____Established Due Date:____/____/____
Ht:_____Pre-Pregnancy Wt:_____

Father of this Baby (skip if sperm donor or unknown):
Name:_____Age of Biological Father:_____

Pregnancy History

Total number of pregnancies (including current if pregnant):
Term deliveries:_____Preterm deliveries (<37 wks)_____
Miscarriages/abortions/ectopics_____ Number of cesarean births:_____
IVF or Fertility treatments with this pregnancy: ❑ Yes ❑ No
If Yes: Are you a surrogate? ❑ Yes ❑ No Donor Embryo? ❑ Yes ❑ No
Donor Egg? ❑ Yes ❑ No Age of Egg Donor:_____ Donor Sperm? ❑ Yes ❑ No

Diagnosed with COVID-19 this pregnancy: ❑ Yes ❑ No Date:____/____/____
Have you ever received a COVID-19 vaccine? ❑ Yes ❑ No
Allergies:_____

Current medications/supplements

MEDICATIONS/SUPPLEMENTS:	DOSE & HOW OFTEN	CURRENTLY TAKING?
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Medical Conditions:_____
_____
Have you used any street drugs since becoming pregnant? ❑ Yes ❑ No
If yes, what:_____
Have you consumed any alcoholic beverages since becoming pregnant? ❑ Yes ❑ No
If yes, what type/amount:_____
Do you smoke? ❑ Yes ❑ No Tobacco: ❑ Yes ❑ No Vaping: ❑ Yes ❑ No
If yes, how much & how often:_____
Do you use marijuana? ❑ Yes ❑ No If yes, what type & how often?_____

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Genetic/Family History

How would you describe your ancestry (check all that apply):

❑ White	❑ French Canadian	❑ Samoan	❑ Vietnamese
❑ African (Black)	❑ Native American	❑ Chinese	❑ Laos
❑ Hispanic	❑ Greek	❑ Cambodian	❑ Taiwanese
❑ Ashkenazi Jewish	❑ Italian	❑ Filipino	❑ Korean
❑ Cajun	❑ Middle Eastern	❑ Japanese	❑ Other Southeast Asian
❑ Guamanian	❑ Hawaiian	❑ Asian-East Indian	❑ Unknown
❑ Other_____		❑ Other_____	

How would you describe the ancestry of the father of this baby (check all that apply):

❑ White	❑ French Canadian	❑ Samoan	❑ Vietnamese
❑ African (Black)	❑ Native American	❑ Chinese	❑ Laos
❑ Hispanic	❑ Greek	❑ Cambodian	❑ Taiwanese
❑ Ashkenazi Jewish	❑ Italian	❑ Filipino	❑ Korean
❑ Cajun	❑ Middle Eastern	❑ Japanese	❑ Other Southeast Asian
❑ Guamanian	❑ Hawaiian	❑ Asian-East Indian	❑ Unknown
❑ Other_____		❑ Other_____	

Do you, the father of this baby, or any close relatives have:

❑ Yes ❑ No 1. Thalassemia
❑ Yes ❑ No 2. Neural tube defect (meningomyelocele, spina bifida, or anencephaly)
❑ Yes ❑ No 3. Congenital heart defect (heart abnormality at birth)
❑ Yes ❑ No 4. Down Syndrome
❑ Yes ❑ No 5. Tay-Sachs
❑ Yes ❑ No 6. Canavan Disease (Ashkenazi Jewish)
❑ Yes ❑ No 7. Familial Dysautonomia (Ashkenazi Jewish)
❑ Yes ❑ No 8. Sickle Cell Disease or trait
❑ Yes ❑ No 9. Hemophilia or other blood disorders
❑ Yes ❑ No 10. Muscular Dystrophy
❑ Yes ❑ No 11. Cystic Fibrosis
❑ Yes ❑ No 12. Huntington Chorea
❑ Yes ❑ No 13. Intellectual disability/developmental delay
❑ Yes ❑ No 14. Other inherited genetic or chromosomal disorders
❑ Yes ❑ No 15. Maternal metabolic disorder (eg. Diabetes, PKU)
❑ Yes ❑ No 16. Patient or baby's father had a child with birth defects not listed above
❑ Yes ❑ No 17. Recurrent pregnancy loss or a stillborn
❑ Yes ❑ No 18. Medications (supplements, vitamins, herbs, OTC, illegal/recreational, complete medication list on page 2)
❑ Yes ❑ No 19. Any other complications_____
❑ Yes ❑ No 20. Are you and the father of this baby blood relatives (i.e. cousins)