EXPOSURES CLINIC INTAKE FORM

Name: _____ **DOB:** _____
MRN: _____ **Indication:** _____
Weight: _____ **Height:** _____ **Referring:** _____

The following information is to be obtained prior to the appointment from the patient directly or the referring provider's office or at time of the appointment.

Pregnant: LMP: _____ EDC: _____ GA: _____ w _____ d Ultrasound: NL ABNL
Preconception: LMP: _____ Status: Not Trying Actively Trying Fertility Treatments
Breastfeeding: Infant Age: _____ Infant Sex: _____ GA @ Delivery: _____

Agent (use back for more)	**Indication**	**Dose/Unit/Freq**	**Route**	**Start Date**	**End Date**	**Side effects or Symptoms**

Other Exposures: Tobacco Alcohol Street Drugs X-Rays Herbals/Probiotics Other Rx Drugs
Maternal Illnesses: Cold/Flu Infection HTN DM Epilepsy/Seizures Genetic Condition

Notes:_____
_____
_____
_____
_____

Database: Y/N Studies: Y/N Studies: ***
Contacts/Recs: GC MFM OB PSYCH METHADONE POISON CNTRL GENETICS LACTATION OTHER