Obstetrical History Form

Obstetrics & Gynecology

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Name of the father of the baby: _____ His Age: _____

Emergency Contact: _____ Phone #: _____

Have you been seen by another provider for this pregnancy? □ Yes □ No

If so, please list provider information: _____

What was the first day of your last normal period? _____

Do you normally have a period every month: □ Yes □ No Every _____ days

Have you had any bleeding since your last period? □ Yes □ No

What day was your pregnancy test first positive? _____

Were you on birth control when you got pregnant? □ Yes □ No

Please list all **medications** that you are currently taking:

_____

_____

_____

Please list all **allergies** to medication/Latex/Iodine/foods:

_____

_____

Past Obstetrical History (List all pregnancies including miscarriages, abortions, tubal/ectopic)

Date/ Month/Yr	GA Week	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Preterm Labor?	Comments Complications

Past Obstetrical History:

How many times have you been pregnant, including this pregnancy? _____

How many live-born babies have you had? _____

Have you ever had a miscarriage: □ Yes □ No

Have you ever had a stillborn baby? □ Yes □ No

Are all your children still living? □ Yes □ No

Were any of your children born with defects? □ Yes □ No

Past Medical History:

Have you ever been diagnosed with any of the following?

□ Diabetes (Type I or II)

□ Hypertension

□ Heart Disease/ Murmur

□ Lupus/Rheumatoid Arthritis/Sjogren's

□ Kidney Disease

□ Recurrent Urinary Tract infections/pyelo/stones

□ Neurologic Disorder (ex. MS)

□ Epilepsy/ Seizures

□ Psychiatric Disorder/ Anxiety, Depression/ Bipolar

□ Liver Disease/Hepatitis A,B,C

□ Blood Clots/DVT/Pulmonary Embolus

□ Bleeding Disorder (Von Willebrand's/Hemophilia)

□ Hypothyroid/Hyperthyroid

□ Rh Isoimmunization

□ Asthma/Tuberculosis

□ Infertility

□ Uterine anomaly

□ DES exposure

□ Auto immune disorders

□ Anemia

□ Cancer

□ Ulcers

□ Fibroids

□ Abnormal Mammo

□ Tubal Infection (PID)

□ Chicken Pox

Have you ever had a blood transfusion? □ Yes □ No Why: _____

Do you smoke? □ Yes □ No

How much before pregnancy? _____ packs/day

How much since you found out you were pregnant? _____ packs/day

Do you drink alcohol? □ Yes □ No

How much before pregnancy? _____ drinks/week

How much since you found out you were pregnant? _____ drinks/week

Do you use any drugs? □ Yes □ No Are you addicted to drugs? □ Yes □ No Have you ever used IV drugs? □ Yes □ No

How much before pregnancy? _____ How much since you found out you were pregnant? _____

What drugs do you regularly use? _____

Past Medical History:

Do you drink Caffeine? □ Yes □ No _____ servings/day

Do you own cats? □ Yes □ No Who normally cares for the litter box? _____

Do you eat fish on a regular basis? □ Yes □ No

Do you plan to get an epidural during labor? □ Yes □ No

Do you plan to have your baby circumcised if it is a male? □ Yes □ No

Do you plan to breast feed? □ Yes □ No

Are you planning on getting your tubes tied? □ Yes □ No

Have you had the vaccine for hepatitis B? □ Yes □ No

Have you been exposed to or ever tested positive for TB (tuberculosis)? □ Yes □ No

Within the past year or since becoming pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? □ Yes □ No

Are you in a relationship with someone who threatens you or physically hurts you? □ Yes □ No

Has anyone forced you to have sexual activities that made you feel uncomfortable? □ Yes □ No

Surgical History:

Please list any surgeries or hospitalizations you have had in the past

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Gynecologic History

Have you ever had an abnormal pap smear? □ Yes □ No When? _____

What treatment was done? _____

When was your most recent pap smear? _____ Results? _____

Have you ever had:

□ Gonorrhea □ Herpes □ Trichomonas □ Hepatitis A/B/C □ Pelvic inflammatory disease

□ Chlamydia □ Syphilis □ HIV/AIDS □ HPV/Genital warts

Have you or anyone in your family ever had any major problems with anesthesia? □ Yes □ No

Explain: _____

Would you accept a blood transfusion if needed in case of emergency? □ Yes □ No

Family History:

	Age	Age at Death	Medical Problems
Mom			
Dad			
Brother			
Brother			
Sister			
Sister			

Was anyone in your family or the father of the baby's family born with any birth defects?

Thalassemia: □ Yes □ No

Spina Bifida/Anencephaly: □ Yes □ No

Congenital Heart Defect: □ Yes □ No

Down Syndrome: □ Yes □ No

Tay-Sachs: □ Yes □ No

Sickle Cell Disease/Trait: □ Yes □ No

Hemophilia: □ Yes □ No

Muscular Dystrophy: □ Yes □ No

Cystic Fibrosis: □ Yes □ No

Huntington's Chorea: □ Yes □ No

Please list any other pertinent medical information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed with patient _____ Date: _____