

Pregnancy History

Patient Name _____ Date of Birth _____ Today's Date _____

Past Medical History *(Please enter the date if you have had any of the following)*

<u>Date</u>	<u>Date</u>	<u>Date</u>
_____ Last Pap Smear	_____ Blood Clots/Varicosities	_____ Hepatitis/Yellow Jaundice/ Liver Disease
_____ Abnormal Pap Smear	_____ Bowel or Stomach Problems	_____ High Blood Pressure/ Stroke
_____ Anemia/Blood Transfusions/ Blood Disease	_____ Cancer	_____ HIV/Genital Herpes
_____ Anesthesia Complications	_____ Diabetes, Type 1/Type 2	_____ Kidney Infections/Kidney Stones/Kidney Disease
_____ Anxiety/Depression/ Psychiatric Condition	_____ Epilepsy/Seizures or Convulsions /Neurologic Disorder	_____ Organ Transplant
_____ Asthma/Chronic Lung Disease/ Pneumonia/Tuberculosis	_____ Heart Disease/Murmurs/ Rheumatic Fever	_____ Thyroid Disorder or Disease

Past Surgical History *(Please enter the date if you have had any of the following)*

<u>Date</u>	<u>Date</u>	<u>Date</u>
_____ Abdominal Surgery	_____ C-Section	_____ Laparoscopy
_____ Appendectomy	_____ Gall Bladder Removal	_____ Other Pelvic Surgery
_____ Breast Surgery	_____ Hernia Repair	_____ Other Surgery

Current Medications

Drug Name	Dosage	Drug Name	Dosage
_____	_____	_____	_____

Allergies *(Please list all substances, as well as the reaction you experienced)*

Past Medical History *(Please enter the date if you have had any of the following)*

<u>Illness</u>	<u>Relative</u>	<u>Illness</u>	<u>Relative</u>
Family History of Anesthesia Reaction	_____	Family History of Drinking Problems	_____
Family History of Blood Clotting Disorder	_____	Family History of Heart Disease	_____
Family History of Breast Cancer	_____	Family History of High Blood Pressure	_____
Family History of Colon Cancer	_____	Family History of Ovarian Cancer	_____
Family History of Diabetes	_____	Family History of Stroke	_____

Pregnancy History

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Reproductive / Menstrual History

Age at onset of Periods _____ Cycle interval (# of days between cycles) _____
 Last Menstrual Period _____ Are your periods regular? _____

Pregnancy History *(Please indicate number)*

Total Pregnancies _____ Full Term Deliveries _____ Pre-Term Deliveries _____
 Miscarriages/Abortions _____ Ectopic Pregnancies _____ Living Children _____

Social History

Race _____ Religion _____ Marital Status _____
 Occupation _____ Level of Exercise _____ Level of Education _____

(Please check all that apply.)

Tobacco Use At Risk of STD Began Sexual Activity before 16
 Alcohol/Drug Use At Risk of HIV Have Had More than 5 Sexual Partners
 History of STD At Risk for Domestic Violence Tested Positive for HIV

OB History Review *(Please check if you have had any of the following)*

History of Stillbirth/Neonatal Death Prior C-Section Placenta Previa
 Prior Infant Admitted to NICU Blood Antibody Sensitization Placental Abruption
 Too Much/Too Little Amniotic Fluid Recurrent Bladder Infections Twin or Triplet Pregnancy
 Prior Infant Weighing More than 9 lbs History of Fetal Distress in Labor History of Group B Strep
 Preeclampsia/High Blood Pressure Gestational Diabetes Recurrent Miscarriages

OB Family History and Genetic History Review

(Please check if anyone in the baby's families have had any of the following)

Tay Sachs Muscular Dystrophy Down Syndrome
 Sickle Cell Trait/Disease Hemophilia Genetic Disorder
 Thalassemia Spina Bifida Birth Defects
 Huntington Chorea Anencephaly Cystic Fibrosis
 Hydrocephaly

Have you ever had chickenpox? yes no Date of Last Menstrual Period _____

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OB Risk Factors *(Please check if you have any of the following)*

- | | | |
|--|---|---|
| <input type="checkbox"/> Mother's age less than 18 or over 35 | <input type="checkbox"/> Black Race | <input type="checkbox"/> Prior Uterine Surgery |
| <input type="checkbox"/> Prior Preterm birth (before 37 weeks) | <input type="checkbox"/> Weight less than 120 lbs | <input type="checkbox"/> DES Exposure |
| <input type="checkbox"/> More than 2 miscarriages req'ing D&C | <input type="checkbox"/> History of STD or Genital Herpes | <input type="checkbox"/> Drug/Alcohol/Tobacco Use |
| <input type="checkbox"/> Psychosocial/Physical Abuse | <input type="checkbox"/> Incompetent Cervix | <input type="checkbox"/> Known Uterine Malformation |

Review of Systems *(Please check if you are currently having problems with any of the following)*

- | | | |
|---|---|--|
| <input type="checkbox"/> General Wellness | <input type="checkbox"/> Stomach, Digestion or Bowels | <input type="checkbox"/> Numbness or Headaches |
| <input type="checkbox"/> Eyes, Ears, Nose or Throat | <input type="checkbox"/> Urination | <input type="checkbox"/> Muscles, Bones or Joints |
| <input type="checkbox"/> Breasts | <input type="checkbox"/> Abnormal Periods | <input type="checkbox"/> Weight Change, Heat Intolerance, Hair Loss/Growth |
| <input type="checkbox"/> Heart, Chest or Lungs | <input type="checkbox"/> Skin | <input type="checkbox"/> Emotions |

Past Pregnancy Details *(Complete for all previous pregnancies, beginning with first)*

Birth Date	Length of Pregnancy (weeks)	Hours of Labor	Birth Weight (lb/oz)	Sex	Type of Delivery	Anesthesia	Early Labor?	Location of Delivery	Delivering Doctor	Complications/Comments