

MEDICAL AND OBSTETRICAL HISTORY

Name: _____ Date: _____
 Address: _____ Phone: _____ (home)
 _____ (work)
 Date of birth: _____
 Occupation: _____
 Education (last grade completed): _____ Degree: _____
 Emergency contact (name and relationship): _____ Phone: _____
 Pediatrician: _____ Breast or Bottle Feed: _____
 First Day of last menstrual period: _____

PREVIOUS PREGNANCIES

Date	Sex	Birth Wt.	Length of Labor	Type of Delivery	Anesthesia	Place of Delivery	Comments/Complaints

MEDICAL HISTORY

	Y	N	Date Tx.		Y	N	Date Tx.
Diabetes				Tuberculosis			
Hypertension				Asthma			
Heart Disease				Drug Allergies			
Rheumatic Fever				Operations/ Hospitalizations			
Mitral Valve Prolapse				History of Abnormal Pap			
Kidney Disease/Urinary Infections				Uterine Problems			
Nervous/Mental Disorders				Infertility			
Epilepsy				DES Exposure			
Hepatitis/Liver Disease				History of Vaginal Infections			
Varicose Veins				History of Genital Herpes			
Thyroid Disease				Partner with Genital Herpes			
Major Accidents				Rash or Infection since Last Menstrual Period			
History of Blood Transfusion							

Use of tobacco:

cigs/day prior to pregnancy _____
 # cigs/day now _____
 age at onset of smoking _____

use of alcohol:

drinks/week prior to pregnancy _____
 # drinks/week now _____
 age at onset of drinking _____

Genetic Screening/History

Include patient, father of the baby or anyone in either of the family

	Y	N		Y	N
1. Are you the age of 35 or will be at time of your delivery?			11. Cystic Fibrosis		
2. Thalassemia (Italian, Greek, Mediterranean, Asian background)			12. Huntington's Disease		
3. Neural Tube Defect (Meningocele, Spina Bifida, or Anencephaly)			13. Maternal Metabolic Disorder (e.g., Type 1 Diabetes, PKU)		
4. Congenital Heart Defect			14. Mental Retardation/ Autism		
5. Down Syndrome			15. If yes to the above, was person tested for Fragile X?		
6. Tay-Sachs Disease (e.g., Jewish, Cajun, French Canadian)			16. Any other inherited genetic or chromosomal disorders?		
7. Canavan Disease			17. Patient or baby's father had a child with birth defect not listed above?		
8. Sickle Cell Disease or Trait (African)			18. Recurrent pregnancy loss or stillbirth		
9. Hemophilia or other blood disorders			19. Medications (includes supplements, vitamins, herbs, OTC)		
10. Muscular Dystrophy			20. Drugs since last menstrual period: If yes, list at bottom of page (comments)		

Infection History	Y	N	
1. Live with someone with TB or exposed to TB			4. Hepatitis B, C Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Patient or partner has history of genital herpes			5. History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis (circle all that apply)
3. Rash of viral illness since last menstrual period			6. Other (list under comments)

PRESENT PREGNANCY

(Explain any symptoms since your last menstrual cycle)

Vaginal Bleeding _____

Vaginal discharge or odor _____

Vomiting _____

Constipation _____

Headache _____

Abdominal pain _____

Urinary Complaints _____

Fever _____

Any type of infection _____

Comments (Number and explain abnormal): _____
