

## OB Patient History

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_ Pediatrician: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status:  Single  Divorced  Widowed  Married

Occupation: \_\_\_\_\_  Full time  Part time  Unemployed  Student

Primary language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Education Completed:  High School  Some college  College graduate  Other: \_\_\_\_\_

### EMERGENCY CONTACT

Contact Name	Relation	Contact Number
	Husband/Domestic Partner	
	Father of Baby	
	Other:	

### PREVIOUS PREGNANCIES:

<b>Total Number of Pregnancies</b>	
Full Term	
Premature	
Induced abortion	
Spontaneous abortion	
Ectopic pregnancies	
Multiple births	
Living children	

### LAST MENSTRUAL PERIOD

Definite Date: \_\_\_\_\_

Approximate date known: \_\_\_\_\_

Date unknown

On birth control pill at conception?  Yes  No

**Prior menses:**

Frequency: every \_\_\_\_\_ days

Menarche (age of onset): \_\_\_\_\_

Date of positive pregnancy test: \_\_\_\_\_

Are blood transfusions acceptable to you if needed?  Yes  No

Do you have a latex allergy?  Yes  No

**DRUG ALLERGIES**

Name of Drug	Reaction	Name of Drug	Reaction

**CURRENT MEDICATIONS (prescription first then over the counter medications)**

Name of Drug	Strength	Frequency

**MEDICAL HISTORY (please check all that apply)**

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	D (RH) Sensitized	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary: TB or Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/Latex allergy reactions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease / UTI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	GYN surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthetic complications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of abnormal pap	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uterine anomaly	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post partum depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis / liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fertility treatment (ART)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Varicosities / Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant Family History	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trauma / Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please explain any YES answers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## HOSPITALIZATION / SURGICAL HISTORY

Year	Reason	Where (City/State)

## SUBSTANCES USED

Name	Amount used pre-pregnancy	Amount used while pregnant	Years used
Tobacco			
Alcohol			
Illicit/Recreational Drugs			

## GENETIC SCREENING

Has patient or baby's father had a child with birth defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had recurrent pregnancy loss or stillbirth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken medications (including supplements, vitamins, herbs or OTC drugs/illicit/recreational drugs or alcohol) since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any YES answers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## INFECTION HISTORY

Do you live with someone or have you been exposed to someone with tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or your partner have a history of genital herpes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a rash or viral illness since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with Hepatitis B or C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you had a history of:</b>	
STD: <input type="checkbox"/> Yes <input type="checkbox"/> No    Gonorrhea: <input type="checkbox"/> Yes <input type="checkbox"/> No    Chlamydia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HPV: <input type="checkbox"/> Yes <input type="checkbox"/> No    HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No    Syphilis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: _____	

History reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_