Obstetrics Appointment Form

Date___________

Name ______________________ Occupation ______________________

Ethnicity ____________________ Age ______________________

Father's name ________________ Phone ______________________

Occupation __________________ Ethnicity ______________________

Partners for how long? ______________________

Religious affiliation _____________ Language preference _________________

Who do you live with? _____________ Pets______________________

Last menstrual period description: ☐ Normal ☐ Lighter ☐ Heavier

Birth control at conception? ☐ Yes ☐ No Type? ______________________

Planned pregnancy? ☐ Yes ☐ No

Pregnancy test date: ______________________ Type? ______________________

Pre-pregnancy weight: ___________ Periods: Regular ______ Irregular______

Menstrual cycle every days: ______ Flow days: ______

Last Pap Test result: __________________

Total number of pregnancies: (*See Pregnancy History document to provide details*)

Full term______ Premature ______ Miscarriage______ Abortion______

<u>Breastfeeding history:</u>

Breastfed previously ___Yes ___No
Problems or complications?_______________________________________

Past medical history (circle once):

Chicken Pox	Yes	No	
Genital Herpes	Yes	No	
Partner w/Herpes	Yes	No	
Other STD:	Yes	No	Explain:____________________________
Group B Strep	Yes	No	
Hepatitis B Risk	Yes	No	
TB Risk	Yes	No	Explain:____________________________
ENT Issues	Yes	No	Explain:____________________________
Heart/High BP	Yes	No	Explain:____________________________
Respiratory/Asthma	Yes	No	Explain:____________________________
Gastrointestinal	Yes	No	Explain:____________________________
Urinary	Yes	No	Explain:____________________________
Breast	Yes	No	Explain:____________________________
Muscle/Skeletal	Yes	No	Explain:____________________________
Neurologic	Yes	No	Explain:____________________________
Psych/Depression	Yes	No	Explain:____________________________
Diabetes	Yes	No	Explain:____________________________
Thyroid	Yes	No	Explain:____________________________
Blood Transfusion	Yes	No	Explain:____________________________
Anemia	Yes	No	Explain:____________________________
Variscosities/DVT	Yes	No	Explain:____________________________
History of Abuse	Yes	No	Explain:____________________________
Gynecological	Yes	No	Explain:____________________________
Abnormal Pap	Yes	No	Explain:____________________________
Cervical Treatments	Yes	No	Explain:____________________________
Infertility	Yes	No	Explain:____________________________

Other:____ _____

Surgical History____
____

Family History: **Relationship**

Diabetes	____________________________
High Blood Pressure	____________________________
Renal Disease	____________________________
Cancer	____________________________
Twins	____________________________
Heart Disease	____________________________
Lung Disease	____________________________
Seizure Disease	____________________________

Same father as most recent pregnancy? Yes No

Genetic History(Circle)	**Patient**		**Father of Baby**	
Age > 34 years	Yes	No	Yes	No
Sickle cell	Yes	No	Yes	No
Thalassemia	Yes	No	Yes	No
Tay-Sachs	Yes	No	Yes	No
Down's syndrome	Yes	No	Yes	No
Mental retardation	Yes	No	Yes	No
Fragile X	Yes	No	Yes	No
Neural tube defect	Yes	No	Yes	No
Cystic Fibrosis	Yes	No	Yes	No
Huntington's Chorea	Yes	No	Yes	No
Muscular Dystrophy	Yes	No	Yes	No
Hemophilia	Yes	No	Yes	No
Other Heritable condition	Yes	No	Yes	No
Other birth defect	Yes	No	Yes	No
>3 Miscarriages or stillbirths	Yes	No	Yes	No

Habits/Exposures:

Tobacco use: ___Current ___ ppd___ Quit <6 months ago___ Quit >6 months ago___ Never

Alcohol use: ___Current ___Exposure during early pregnancy

Illicit drug use: ___Current ___Exposure during early pregnancy ___Never

X-Rays during early pregnancy ___Yes ___No Explain:_______________________

Other Medications in early pregnancy ___Yes ___No
Explain:____

Current medications:____

Drug allergies:
____
____

Allergic to latex? Yes_____No____

Pregnancy History Record

Year	Delivery location	Number of weeks pregnant	Vaginal delivery or c-section	Number of hours in labor	Pain management methods	Complications	Name Weight Gender

Patient Name____