NAME: _____ DATE: ____/____/____

BIRTHDATE: ____/____/____ AGE: _____

NAME PREFERRED TO BE CALLED: _____

REFERRED BY: _____

REASON FOR VISIT: ☐ ANNUAL ☐ PROBLEM

DESCRIBE PROBLEM: _____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)		List:			

OB	YES	NO		YES	NO
MAJOR ILLNESSES					
Anemia			Hepatitis / Jaundice		
Anxiety			Herpes / HSV		
Arthritis / Joint pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			HIV / AIDS		
Breast Cancer			Kidney Infections / Urinary Tract Infections		
Cancer (Please specify)			Kidney Stones		
Chlamydia			Pneumonia		
Chronic Lung Disease			Rheumatic Fever		
Depression			Mood Disorders		
Diabetes (please specify)			Stroke		
Eating Disorder (please specify)			Syphilis		
Fracture			Tuberculosis - TB		
Gastrointestinal problems (please specify)			Tubal Ligation		
Glaucoma			Thyroid Disease(please specify)		
Gonorrhea / GC			Ulcers		
Heart problems			OTHER:		

OB

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:			
MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE: Mother's / Father's
Anemia			
Arthritis/Joint Pain			
Asthma			
Bowel Trouble/Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression/Anxiety/Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble/Murmur			
Hepatitis/Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections/Stones			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			
Page 3 of 9			

OB CIRCLE AND CHECK IF YOU, THE FATHER OF THE BABY, OR ANY BLOOD RELATIVE HAVE HAD:			
GENETIC SCREENING	YES	NO	WHO?
Cystic Fibrosis			
Down syndrome, mental retardation, autism, fragile X			
Heart defects at birth			
Hemophilia			
Huntington chorea			
Maternal metabolic disorder (insulin dependent diabetes, PKU			
Muscular dystrophy			
Neural tube defects, spina bifida, anencephaly, menigomyelocele			
Patient or father of baby had a child with birth defects not listed above			
Recurrent pregnancy loss or a still birth			
Sickle cell disease or trait (African)			
Taken any medications, drugs, alcohol since your last period			
Tay Sachs disease (Jewish, Cajun or French Canadian)			
Thalassemia, Italian, Greek, Mediterranean or Asian background			
Other inherited genetic or chromosomal disorder			
What:			

OB	WHEN WAS YOUR LAST TEST OR IMMUNIZATION?		
Flu Shot	DATE		DATE
Pneumonia		T B Skin Test	
Chicken Pox		Tetanus	

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:			
TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:			
SURGERY / HOSPITALIZATION / REASON	DATE	SURGERY / HOSPITALIZATION / REASON	DATE

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living children	

YOUR GYN HISTORY

Were you using any birth control when you got pregnant? ☐ Yes ☐ No	
❑ Condoms	❑ Nuvaring
❑ Depo Provera	❑ Birth Control Patch
❑ Diaphragm	❑ None
❑ IUD- Kind	❑ Natural Family Plan/Rhythm
- Date Inserted:	❑ Tubal Ligation
❑ Birth Control Pill	❑ Vasectomy
– Name:	❑ Withdrawal
❑ Contraceptive Foam/Jelly	❑ Other:

What tests have you had done and when?

Bone Density _____ Mammogram_____

Colonoscopy/Sigmoidoscopy _____ Last Normal PAP Smear _____

Last abnormal Pap smear _____

Previous treatment of abnormal Pap _____

What age did you have your first period: _____

How many days are there from start of your period to start of next period? _____ days

How long does your period last? _____ days Flow: ☐ Light ☐ Medium ☐ Heavy

Date of Last Period: _____ Are you sure of the date? ☐ Yes ☐ No

Was it a normal period? ☐ Yes ☐ No

OB

NAME: _____

BIRTHDATE: _____/_____/_____

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type Vag/CSection	Epid Y / N	Preterm Labor?	Wt Gain	Comments / Complications	Hospital
1					M F						
2					M F						
3					M F						
4					M F						
5					M F						
6					M F						

OB NAME: _____BIRTHDATE: _____/_____/_____

PLEASE LIST HABITS

Do you use a seat belt? ☐ Yes ☐ No

Do you have an infant car seat? ☐ Yes ☐ No

Do you plan to take childbirth classes? ☐ Yes ☐ No

Do you plan to breastfeed your baby? ☐ Yes ☐ No

Do you plan to have an epidural for labor? ☐ Yes ☐ No

Do want your tubes tied after the birth of this baby? ☐ Yes ☐ No

If you have a son, do you want to have him circumcised? ☐ Yes ☐ No

If you've had a Cesarean section, do you want a repeat C-Section? ☐ Yes ☐ No

Are you planning any out of town trips during this pregnancy? ☐ Yes ☐ No

What was your pre pregnancy weight?

Are there any religious or cultural preferences that would affect your care? ☐ Yes ☐ No

What:

What do you plan to use for contraception after the birth of your baby?

☐Condoms ☐DepoProvera ☐Diaphragm ☐IUD ☐Birth Control Pill

☐Foam/Jelly ☐Nuvaring ☐Birth Control Patch ☐None ☐Tubal Ligation

☐Vasectomy ☐Withdrawal ☐Natural Family Planning/Rhythm ☐Other

Do you have a pediatrician?

☐ Yes ☐ No Who?_____

Do you have a cat? ☐ Yes ☐ No

Do you clean the litter box? ☐ Yes ☐ No

Do you do a Self Breast Exam? ☐ Yes ☐ No How often:_____

Do you Exercise?

☐ None ☐ Less than 3 times per week ☐ More than 3 times per week

OB

Smoking ☐ Yes ☐ No ☐ Previously

Packs per day: _____ Number of Years: _____ Stopped _____ Years ago

Alcohol ☐ Yes ☐ No ☐ Previously

Drinks per day: _____ Drink per week: _____

Drug User ☐ Yes ☐ No ☐ Previously

Kind: Frequency:

History of abuse ☐ Yes ☐ No

☐ Physical ☐ Emotional ☐ Sexual

Occupation:

Race ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

Marital Status ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed