Obstetrical History Form

Obstetrics & Gynecology

Name____ Date____________________
first middle last

Age________ Date of Birth___________________________ Occupation_________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of the father of the baby:____ His Age_____

Emergency Contact:__________________________________ Phone number:___________________________

What was the first day of your last normal period?_____________________

Do you normally have a period every month? ☐ Yes ☐ No Every _________ days

Have you had any bleeding since your last period? ☐ Yes ☐ No

What day was your pregnancy test first positive?_______________________

Were you on birth control when you got pregnant? ☐ Yes ☐ No

Please list all medications that you are currently taking:____

____

____

____

____

Please list all allergies to medications/Latex/Iodine/foods:____

____

____

____

____

PAST OBSTETRICAL HISTORY (List all pregnancies including miscarriages, abortions, tubal/ectopic)

Date	Length of pregnancy	D&C	Vaginal/C-Section	Girl/Boy	Weight	Complications

web0212

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

☐ Diabetes
☐ Hypertension
☐ Heart Disease/Murmur
☐ Lupus/Rheumatoid Arthritis/Sjogrens
☐ Kidney Disease
☐ Rh Isoimmunization
☐ Asthma/TB
☐ Infertility
☐ Uterine anomaly
☐ DES exposure
☐ Recurrent urinary tract infections/pyelo/stones
☐ Neurologic Disorder (ex. MS)
☐ Epilepsy/Seizures
☐ Psychiatric Disorder/Anxiety/Depression/Bipolar
☐ Liver Disease/Hepatitis A, B, C
☐ Blood Clots/DVT/Pulmonary Embolus
☐ Bleeding Disorder (Von Willebrands/Hemophilia)
☐ Hypothyroid/Hyperthyroid

Have you ever had a blood transfusion? ☐ Yes ☐ No Why?_______________________________________

____

Do you smoke? ☐ Yes ☐ No

How much before pregnancy? _________packs/day

How much since you found out you were pregnant? _________packs/day

Do you drink alcohol? ☐ Yes ☐ No

How much before pregnancy? _________drinks/week

How much since you found out you were pregnant? _________drinks/week

Do you use any drugs? ☐ Yes ☐ No

How much before pregnancy?____

How much since you found out you were pregnant?_______________________________

What drugs do you regularly use?____

Have you ever used IV drugs? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No _________servings/day

Do you own cats? ☐ Yes ☐ No Who normally cares for the litter box?_____________________

Do you eat fish on a regular basis? ☐ Yes ☐ No

Do you plan to get an epidural during labor? ☐ Yes ☐ No

Do you plan to have your baby circumcised if it is a male? ☐ Yes ☐ No

Do you plan to breast feed? ☐ Yes ☐ No

Are you planning on getting your tubes tied? ☐ Yes ☐ No

Have you had the vaccine for hepatitis B? ☐ Yes ☐ No

Have you been exposed to or ever tested positive for TB (tuberculosis)? ☐ Yes ☐ No

Have you had the chicken pox? ☐ Yes ☐ No

Within the past year or since becoming pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No

Are you in a relationship with someone who threatens you or physically hurts you? ☐ Yes ☐ No

Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

SURGICAL HISTORY

Please list any surgeries or hospitalizations you have had in the past

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

FAMILY HISTORY

	Age	Age at Death	Medical Problems
Mom			
Dad			
Brother			
Brother			
Sister			
Sister			

Was anyone in your family or the father of the baby's family born with any birth defects?

Thalassemia: ☐ Yes ☐ No

Spina Bifida/Anencephaly: ☐ Yes ☐ No

Congenital Heart Defect: ☐ Yes ☐ No

Down Syndrome: ☐ Yes ☐ No

Tay-Sachs: ☐ Yes ☐ No

Sickle Cell Disease/Trait: ☐ Yes ☐ No

Hemophilia: ☐ Yes ☐ No

Muscular Dystrophy: ☐ Yes ☐ No

Cystic Fibrosis: ☐ Yes ☐ No

Huntington's Chorea: ☐ Yes ☐ No

Mental Retardation/Autism: ☐ Yes ☐ No

Other inherited chromosomal/genetic disorder: ☐ Yes ☐ No

Maternal metabolic disorder (insulin dependent diabetes, PKU): ☐ Yes ☐ No

Recurrent pregnancy loss or stillbirth: ☐ Yes ☐ No

Are you Ashkenazi Jewish? ☐ Yes ☐ No

GYNECOLOGIC HISTORY

Have you ever had an abnormal pap smear? ☐ Yes ☐ No When?________________________________

What treatment was done?____

____

When was your most recent pap smear?____________________ Results?__________________________

Have you ever had:

☐ Gonorrhea	☐ HIV/AIDS
☐ Chlamydia	☐ Hepatitis A/B/C
☐ Herpes	☐ Syphilis
☐ HPV/Genital warts	
☐ Pelvic inflammatory disease	

Have you or anyone in your family ever had any major problems with anesthesia? ☐ Yes ☐ No

Explain:____

Would you accept a blood transfusion if needed in case of emergency? ☐ Yes ☐ No

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

____

____

____

____

____

____

____

____

____

____

____

____

Reviewed with patient____Date_____________