NAME_____DOB_____

MEDICAL / SURGICAL and OBSTETRICAL HISTORY

PREGNANCY HISTORY

Pregnancy # Baby's Name	Date	Doctor's Name	Weeks at Delivery	Weight /Sex	Normal / Cesarean – complications

Other:_____

_____

SINCE LAST MENSTRUAL PERIOD: _____(date of Last Period)
Any Exposure to: Fever, Medications, Radiation, Viral Illness, other substances? If yes, please specify:_____

_____

MEDICAL / SURGICAL HISTORY

No	Yes		No	Yes		No	Yes	
O	O	Diabetes	O	O	Trauma/ Violence	O	O	Breast Problems
O	O	Hypertension (blood pressure)	O	O	History of Blood Transfusions	O	O	Gyn Surgery
O	O	Heart Disease			before / during pregnancy	O	O	Operations/Hospitalization
O	O	Auto Immune Disorder	O	O	Tobacco /	O	O	Anesthetic Complications
O	O	Kidney Disease	O	O	Alcohol /	O	O	Abnormal Pap Smear
O	O	Neurologic/ Epilepsy	O	O	Drugs /	O	O	Uterine Anomaly/ DES
O	O	Psychiatric	O	O	Rh sensitized	O	O	Infertility
O	O	Depression / post-partum	O	O	Pulmonary (Asthma, etc)	O	O	IVF
O	O	Hepatitis/ liver Disease	O	O	Seasonal Allergies	O	O	Relevant Family history
O	O	Varicosities/ Phlebitis	O	O	Latex / Drug Allergies			
O	O	Thyroid Dysfunction						

_____

INFECTION HISTORY

No	Yes		No	Yes		No	Yes	
O	O	History of TB / Exposure	O	O	Hepatitis B, C	O	O	HIV
O	O	Pt or Partner with Herpes	O	O	STD/ STI	O	O	Chlamydia
O	O	Rash / viral illness since pregnant	O	O	HPV	O	O	Syphilis
			O	O	Gonorrhea			

Medical Conditions	Surgeries	Year

NAME_____

ALLERGIES

_____

_____

_____

GENERAL

No	Yes		No	Yes		No	Yes	
O	O	Agree to Blood Transfusion	O	O	Wears Seat belt	O	O	Plans to Take Prenatal Classes
O	O	Anesthesia Consult Needed						
O	O	Desires Tubal ligation / Sterilization	Planned Baby Feeding		O Breast	O Bottle		O Both
O	O	Enrolled in WIC Prenatal Care Program						

GENETIC SCREENING / RISK FACTORS
(include patient, baby's father or anyone in family)

No	Yes		Mother	Father	Relative
O	O	Patient will be 35 years or older at the time of delivery			
O	O	Thalassemia	O	O	O
O	O	Neural Tube Defect (spina bifida, spinal defect)	O	O	O
O	O	Congenital Heart Defect	O	O	O
O	O	Down Syndrome (or other chromosomal defect)	O	O	O
O	O	Tay-Sachs, Canavan, Gaucher (Ashkenazi Jewish)	O	O	O
O	O	Familial Dysautonomia	O	O	O
O	O	Sickle Cell Disease or Trait	O	O	O
O	O	Hemophilia or other Blood Disorder	O	O	O
O	O	Muscular Dystrophy	O	O	O
O	O	Cystic Fibrosis	O	O	O
O	O	Huntington's Chorea	O	O	O
O	O	Mental Retardation / Autism	O	O	O
O	O	Other inherited Chromosomal / Genetic Disorder	O	O	O
O	O	Maternal Diabetes /Thyroid Disorder	O	O	O
O	O	Other Birth Defects	O	O	O
O	O	Recurrent pregnancy loss or stillbirth	O	O	O
O	O	Medications (including vitamins, over the counter medications (illicit drugs, alcohol, etc. since last period)_____			

_____

_____

Demographic Information
Patient:
Primary Language_____ Birthplace_____ Ethnicity_____
Marital Status_____ Occupation_____ Employer_____
Education Level_____ Religion_____
Exercise Frequency/ Type_____

Father of Baby (or other significant family member):
Name_____ Occupation_____ Ethnicity_____
Emergency Phone Number_____

NAME_____

OB HIGH RISK FACTORS

No	Yes	PATIENT PROFILE
O	O	Age under 20 or over 35
O	O	Less than 8th grad education
O	O	Small Pelvis
O	O	Small stature (< 5 feet)
		ADDICTION
O	O	Alcohol
O	O	Drug use
O	O	Smoking
		SOCIAL FACTORS
O	O	Abusive Relationship
O	O	Exposure to cats
O	O	Lacks Family Support
O	O	Poor Living Environment
O	O	Significant Social issues
		GYNECOLOGIC HISTORY
O	O	Cervical lacerations/Cone
O	O	Incompetent Cervix
O	O	Infertility
O	O	Past Uterine Surgery
O	O	Previous Abnormal Pap
O	O	Uterine Anomalies
O	O	Multiple Prior Deliveries (more than 4?)

No	Yes	PAST PREGNANCY
O	O	2 or more abortions
O	O	5 or more prior deliveries
O	O	Abnormal labor
O	O	ABO Incompatibility
O	O	Anesthetic Intolerance
O	O	Cervical Incompetence
O	O	Chorioamnionitis
O	O	Congenital Anomalies
O	O	Cesarean Section
O	O	Fetal / Neonatal Death
O	O	Gestational Diabetes
O	O	Group B Strep Positive
O	O	Hemorrhage during pregnancy
O	O	Infant > 4000 gm or 9 lbs
O	O	Intrauterine Growth Restriction
O	O	Late Delivery
O	O	Low Birth Weight infant
O	O	Neurologically injured baby
O	O	Oligohydramnios
O	O	Placenta Previa
O	O	Polyhydramnios
O	O	Pre-eclampsia/Eclampsia
O	O	Premature Birth
O	O	Premature Rupture Membranes
O	O	Rh Isoimmunization

No	Yes	THIS PREGNANCY
O	O	2nd pregnancy in 12 months
O	O	Bleeding
O	O	Abnormal labor
O	O	Oligohydramnios
O	O	Polyhydramnios
O	O	Placental Abruption
O	O	Poor Compliance
O	O	Premie Rupture Membranes
O	O	Pregnancy Hypertension
O	O	Threatened Premature Labor
O	O	Uncertain Dates
O	O	Excessive Weight gain
O	O	Poor Weight gain

No	Yes	MEDICAL HISTORY
O	O	Anemia
O	O	Anticoagulant use
O	O	Heart Disease, mild
O	O	Heart Disease, mod/severe
O	O	Chronic Renal Disease
O	O	Diabetes Mellitus
O	O	Epilepsy / Seizures
O	O	Hepatitis
O	O	Herpes Simplex
O	O	HIV
O	O	Hyptertension
O	O	Lung Disease
O	O	Phenylketonuria
O	O	Thromboembolism
O	O	Thyroid Disfunction