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
- O O Diabetes
- O O Hypertension (blood pressure)
- O O Heart Disease
- O O Auto Immune Disorder
- O O Kidney Disease
- O O Neurologic/ Epilepsy
- O O Psychiatric
- O O Depression / post-partum
- O O Hepatitis/ liver Disease
- O O Varicosities/ Phlebitis
- O O Thyroid Dysfunction

No Yes
- O O Trauma/ Violence
- O O History of Blood Transfusions

before / during pregnancy
- O O Tobacco /
- O O Alcohol /
- O O Drugs /
- O O Rh sensitized
- O O Pulmonary (Asthma, etc)
- O O Seasonal Allergies
- O O Latex / Drug Allergies

No Yes
- O O Breast Problems
- O O Gyn Surgery
- O O Operations/Hospitalization
- O O Anesthetic Complications
- O O Abnormal Pap Smear
- O O Uterine Anomaly/ DES
- O O Infertility
- O O IVF
- O O Relevant Family history

INFECTION HISTORY

No Yes
- O O History of TB / Exposure
- O O Pt or Partner with Herpes
- O O Rash / viral illness since pregnant

No Yes
- O O Hepatitis B, C
- O O STD/ STI
- O O HPV
- O O Gonorrhea

No Yes
- O O HIV
- O O Chlamydia
- O O Syphilis

| 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 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 |