OB Patient History

(DO NOT LEAVE ANYTHING BLANK)

Patient:_____ Partner:_____

Date of Last Period:_____ Date of Home Pregnancy Test:_____ Age of First Period:_____

Period Cycle Regular or Irregular (circle one) #Days Between Cycles: 28, 30, Other:___ # Days of Bleeding:____

Past Pregnancy History

Date mm/dd/yyyy	Time Delivered 00:00 am/pm	GA*	Length of Labor	Birth Wt	Sex	Vaginal or C-Section	Epidural	Hospital or City of Delivery	Complication

*GA=Number of weeks pregnant at the time of delivery

Personal and Family Medical History

History	Y/N*	Who?	History	Y/N*	Who?	History	Y/N*	Who?
Allergic Rhinitis			Diabetes			Trauma History		
Anemia/ Hematologic			Heart Disease			Uterine Abnormalities		
Asthma/ Pulmonary			Hypertension			Varicosities or DVT		
Abnormal Pap Smear			Infertility			Anesthetic Complications		
Autoimmune Disorder			Liver Disease			Other Family History		
Blood Transfusion			Neurologic Disorder					
Breast Disorder			Renal Disease					
Depression			(Rh) Sensitized					
Psychiatric Disorder			Thyroid Disorder					

*Y/N= Yes or No

Substance Abuse

Substance	Y/N*	Amt/Day PrePreg	Amt/Day Pregnant	# Years Use
Tobacco				
Alcohol				
Illicit Drugs				

*Y/N= Yes or No

Surgical History

Type of Procedure	Year	Cmt*

*Cmt= Comment

(Continued on Back)

Genetic Screening

Disorder	Y/N*	What Relative?	Disorder	Y/N*	What Relative?
Patient Age Over 35			Autism		
Neural Tube Defect (Spina Bifida, Anenceohaly)			If yes: Was person tested for Fragile X?		
Trisomy 21 (Down Syndrome)			Mental Retardation		
Congenital Heart Defect			If yes: Was person tested for Fragile X?		
Cystic Fibrosis			Muscular Dystrophy		
Tay-Sachs			Sickle Cell Disease or Trait		
Thalassemia			Other Inherited Genetic Disorder		
Canavan Syndrome			Maternal Metabolic Syndrome		
Hemophilia			Recurrent Pregnancy Loss		
Huntington's Chorea			Other Birth Defects		
			Other Genetic Screening		

*Y/N= Yes or No

Exposure/Infection History

History	Y/N*	Cmt*	History	Y/N*	Cmt*
Patient/Partner has History of HIV			Rash or Viral Illness since last menstrual period		
Patient/Partner has History of Genital Herpes			Sexually Transmitted Disease		
Exposure to TB			Other Exposure or Infection		
Had Varicella (Chicken Pox) as a child or adult					

*Cmt= Comment

Current Medications:

Active Allergies: