

OB Patient History

Date: _____

Patient's Name: _____ DOB: _____ Age: _____

Referred by: _____ Pediatrician: _____

Primary Care Provider: _____

Race: _____ Marital Status: Single Divorced Widowed Married

Occupation: _____ Full time Part time Unemployed Student

Primary language: _____ Ethnicity: _____

Education Completed: High School Some college College graduate Other: _____

EMERGENCY CONTACT

Contact Name	Relation	Contact Number
	Husband/Domestic Partner	
	Father of Baby	
	Other:	

PREVIOUS PREGNANCIES:

Total Number of Pregnancies	
Full Term	
Premature	
Induced abortion	
Spontaneous abortion	
Ectopic pregnancies	
Multiple births	
Living children	

LAST MENSTRUAL PERIOD

Definite Date: _____

Approximate date known: _____

Date unknown

On birth control pill at conception? Yes No

Prior menses:

Frequency: every _____ days

Menarche (age of onset): _____

Date of positive pregnancy test: _____

Are blood transfusions acceptable to you if needed? Yes No

Do you have a latex allergy? Yes No

DRUG ALLERGIES

Name of Drug	Reaction	Name of Drug	Reaction

CURRENT MEDICATIONS (prescription first then over the counter medications)

Name of Drug	Strength	Frequency

MEDICAL HISTORY (please check all that apply)

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	D (RH) Sensitized	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary: TB or Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/Latex allergy reactions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease / UTI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	GYN surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthetic complications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of abnormal pap	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Uterine anomaly	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post partum depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis / liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fertility treatment (ART)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Varicosities / Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant Family History	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trauma / Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please explain any YES answers: _____

HOSPITALIZATION / SURGICAL HISTORY		
Year	Reason	Where (City/State)

SUBSTANCES USED			
Name	Amount used pre-pregnancy	Amount used while pregnant	Years used
Tobacco			
Alcohol			
Illicit/Recreational Drugs			

GENETIC SCREENING	
Has patient or baby's father had a child with birth defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had recurrent pregnancy loss or stillbirth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken medications (including supplements, vitamins, herbs or OTC drugs/illicit/recreational drugs or alcohol) since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any YES answers: _____

INFECTION HISTORY	
Do you live with someone or have you been exposed to someone with tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or your partner have a history of genital herpes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a rash or viral illness since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with Hepatitis B or C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a history of:	
STD: <input type="checkbox"/> Yes <input type="checkbox"/> No Gonorrhea: <input type="checkbox"/> Yes <input type="checkbox"/> No Chlamydia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HPV: <input type="checkbox"/> Yes <input type="checkbox"/> No HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No Syphilis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: _____	

History reviewed by: _____ Date: _____