**OB Health History**

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| **PREG**  **LIST** | **Notes** | Patient Name: | Date of Birth: **/ /** | Age: |
| Insurance: | Pt. Ethnicity: White Hispanic African American Other | |
| Father of baby: | FOB Ethnicity: White Hispanic African American Other | |

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| **EDD/ FORM A/GYN** | When was the first day of your **last menstrual period**? | **/ /** |  | **PHYSICAL** | **For office use only** | |
| Is the above date: (circle one) Definite Unsure Unknown | |
| Do you have **regular monthly periods**? | Yes No |
| **How far apart** are your menstrual periods? |  | Height |  |
| How old were you when you had your **first period**? |  | Weight |  |
| Were you taking **birth control pills** when you became pregnant? | Yes No | Pre preg. Wt |  |
| What is the date of your most recent **positive pregnancy test**? | **/ /** | Blood Pressure | **/** |

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| **FORM A (OB HX)** | PREGNANCY HISTORY | |  | **RX** | MEDICATIONS AND ALLERGIES | | |
| **Total** pregnancies |  |
| Number of **full term** deliveries |  |
| Number of **preterm** deliveries |  | Please list any medication you are **currently taking**: |  | |
| Number of induced **abortions** |  |
| Number of **miscarriages** |  | Please list any medications you have taken since becoming pregnant: |  | |
| **Ectopic** pregnancies (tubal) |  |
| **Multiple** births (i.e. twins) |  | Do you have any **allergies** to medications? If so, please list: | Yes No |  |
| **Living children** |  |

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| **FORM A** | PREVIOUS PREGNANCY INFORMATION | | | | | | | |
| Date of Birth | Delivery Type | Birth Weight | Gender | Full Term? Over 37 wks. | Complications with newborn or mother? | Baby’s Name | Comments |
| **/ /** |  |  | M F | Y N |  |  |  |
| **/ /** |  |  | M F | Y N |  |  |  |
| **/ /** |  |  | M F | Y N |  |  |  |
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| **GENETICS HISTORY** | GENETICS HISTORY  Do you, the baby’s father, or anyone in the family have any of the following medical problems? | | |  | **GENETICS HX – GYN HX** | INFECTION HISTORY | | | |
| Do you or your partner have a history of **genital herpes**? | Yes | No | |
| Congenital heart defect? | Yes | No | Have you had a **rash or viral illness** since your last menstrual period? | Yes | No | |
| Cystic fibrosis? | Yes | No |
| Down Syndrome? | Yes | No | Have you ever had a **sexually transmitted disease**? Specify below: | Yes | No | |
| Family history of birth defects? | Yes | No |
| Hemophilia? | Yes | No | Chlamydia Gonorrhea Syphilis  Genital warts HPV Herpes Trich | | | |
| Hydrocephaly? | Yes | No |
| Intellectual disability/Autism? | Yes | No | Date of last **pap: / /** | | | |
| Neural tube defects? | Yes | No | Was your last pap result **normal**? | Yes | | No |
| Have you had the chicken pox or vaccine? | Yes | No | Lifetime **number of sexual partners**? |  | | |
| Previous fetus/infant with a birth defect? | Yes | No | VACCINATION STATUS | | | |
| Recurrent pregnancy loss or stillbirth? | Yes | No | Date of last **tetanus or Tdap vacc: / /** | | | |
| Spina Bifida? | Yes | No | Date of last **influenza vaccination: / /** | | | |

PLEASE COMPLETE BOTH SIDES

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| **SURGICAL HX** | Have you had any **surgeries**? YES NO | |  | **HOSPITALIZATION HX** | Have you been **hospitalized** for illnesses other than surgeries or child birth?  YES NO | |
| DATE | SURGERY |
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|  |  | DATE | REASON |
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| **FAMILY HISTORY** | Do any of your **family members** have any of the following medical conditions? | | | | | | | | |
|  | HEART DISEASE | HIGH BLOOD PRESSURE | DIABETES | THYROID  DISORDERS | CANCER | OSTEOPOROSIS | CLOTTING  (DVT, PE) | OTHER |
| Father |  |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |  |
| Son |  |  |  |  |  |  |  |  |
| Daughter |  |  |  |  |  |  |  |  |

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| **SOCIAL HX** | Do you smoke? | Yes | No | Past |
| If yes, how many cigarettes daily? | | | |
| Do you use **alcohol**? | Yes | No | Prior to preg. |
| Do you use **street drugs**? | Yes | No | Past |
| Do you feel threatened or have you been a **victim of abuse**? | Yes | No | Past |
| **Marital Status**: | Married | Single | Separated |

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| **MEDICAL HISTORY** | Have you had in the past, or do you currently have, any of the following **medical problems**? | | | | | |
| Placental abruption in a prior pregnancy? | Yes | No | Rh negative blood type? | Yes | No |
| Heart disease? | Yes | No | Rh sensitization? | Yes | No |
| High blood pressure? | Yes | No | Pulmonary problems / TB, asthma? | Yes | No |
| Autoimmune disorder? | Yes | No | Seasonal allergies? | Yes | No |
| Kidney disease / UTI? | Yes | No | Drug or latex allergy reactions? | Yes | No |
| Neurological disorder / epilepsy? | Yes | No | Breast problems? | Yes | No |
| Depression / postpartum depression? | Yes | No | Gynecological surgery? | Yes | No |
| Hepatitis / Liver disease? | Yes | No | Operations / hospitalizations? | Yes | No |
| Varicose veins / phlebitis? | Yes | No | Anesthesia complications? | Yes | No |
| Thyroid disorder? | Yes | No | History of abnormal pap? | Yes | No |
| Trauma / violence? | Yes | No | Uterine abnormality? | Yes | No |
| History of blood transfusion? | Yes | No | Infertility? | Yes | No |
| History of tobacco use? | Yes | No | Diabetes? | Yes | No |
| History of alcohol use? | Yes | No | Other medical concerns: List below | Yes | No |
| History of illicit / recreational drug use? | Yes | No |  | | |

Is there anything else in your past medical or OB history that we should know so that we can provide you with the best possible care?