Greater Washington
Maternal-Fetal Medicine
and Genetics

Appointment Date: _____

Name of your Obstetrician: _____

Obstetrician's Office Location: (City) _____

Reason for referral? _____

_____

When was the 1st day of your last menstrual period?_____

What is your due date?_____Is this a twin/triplet pregnancy? _____

What medications are you currently taking? _____

_____

Are you taking Lovenox? _____Do you have Rh negative blood type? _____

What is your pre-pregnancy weight?_____Current Weight :_____Height:_____

Do you have now or have you had any of the following conditions:

	current preg	prior preg
History of C-section		
History of surgery on cervix		
Pre-term labor		
Delivery of premature baby		
High blood pressure		
Diabetes or gestational diabetes		
Blood or clotting disorders		
Pregnancy by fertility treatment (ivf etc)		

How many times have you been pregnant including miscarriages, abortions, and children you have given birth to?

Miscarriage: (if any) _____ Abortions: (if any) _____

Children you have given birth to? (if any) _____ Ages: _____

Have you had any other pregnancy losses? _____

Are there any issues regarding your obstetrical or medical history that we should be aware of?

_____

_____

Please list any drug/latex allergies: _____

_____ _____

Patient's signature Printed Patient's Name