Obstetrical History Form

NAME: _____ DOB: _____ DATE: _____

PERSONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

PARTNER: _____ PARTNER'S PH: _____

Your Occupation: _____ Highest Degree Earned: _____

How much do you exercise? _____

Do you use any of the following?	Before Pregnancy	During pregnancy:	Amount/Years of use
Caffeine:	☐Yes ☐No	☐Yes ☐No	_____
Tobacco:	☐Yes ☐No	☐Yes ☐No	_____
Alcohol:	☐Yes ☐No	☐Yes ☐No	_____
Illicit/Recreational Drugs:	☐Yes ☐No	☐Yes ☐No	_____

Are you concerned about weight? ☐Yes ☐No Have you ever had an eating disorder? ☐Yes ☐No

Is violence at home a concern? ☐Yes ☐No Have you ever been abused? ☐Yes ☐No

In the event of an emergency, is blood transfusion acceptable? ☐Yes ☐No

Please list any personal and/or religious beliefs related to pregnancy that you want your doctor to know:

_____

MENSTRUAL HISTORY

Last Menstrual Period: _____ ☐ Definite ☐ Approximate ☐ Unknown

Menses regular: ☐Yes ☐No Frequency: Every ____ days Flow: Light/Heavy/Normal

On Birth control at conception ☐Yes ☐No Previous birth control methods: _____

Age at first menstrual period: _____ Pre-Pregnancy Weight: _____

MEDICATIONS

Allergies: _____ Latex Allergy: ☐Yes ☐No

Current Medications: ☐Prenatal Vitamins ☐ Iron ☐ Folic Acid

Medication	Dose	Times per Day	Medication	Dose	Times per Day

Pharmacy/Location: _____

VACCINES

The following vaccines are strongly recommended in pregnancy for the health and safety of you and your baby. They are considered **safe** in pregnancy and they give your infant immunity until they can receive the vaccines themselves.

Do you **refuse** the TdaP vaccine (after 27 weeks)? ☐ No ☐ Yes

Do you **refuse** the flu vaccine (during Flu season)? ☐ No ☐ Yes

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INFECTION HISTORY

Illness	Yes	No	Illness	Yes	No
1. Live with or exposed to someone With TB			6. HPV		
			7. Abnormal Pap smear		
2. You or partner has history of genital herpes			8. HIV or AIDS		
			9. Syphilis		
3. Rash or viral illness since last menstrual period			10. Other Sexually transmitted infection? Please indicate		
4. Hepatitis B, C					
5. Gonorrhea, Chlamydia (Circle if yes)			11. Other Infection? Please indicate		

GENETIC SCREENING

Include yourself, Baby's Father, or anyone in either family with the following to the best of your ability

Illness	Yes	No	Illness	Yes	No
1. Your age 35 years or older as of due date			11. Muscular Dystrophy		
			12. Cystic Fibrosis		
2. Thalessemia			13. Huntington's Chorea		
3. Neural Tube Defect			14. Mental Retardation		
4. Congenital Heart Defect			15. Other genetic/chromosomal disorder		
5. Down Syndrome					
6. Tay-Sachs Disease			16. Maternal metabolic disorder (Diabetes, PKU)		
7. Canavan Disease					
8. Familial Dysautonomia			17. Child with birth defects		
9. Sickle Cell Anemia			18. Recurrent pregnancy loss or still birth		
10. Hemophilia					

Any Medications, alcohol, illicit or recreation drugs since last period? Please list. _____

_____

_____

FAMILY HISTORY ☐ Adopted ☐ Family History Unknown

Please indicate if anyone in your family (parents, grandparents, siblings, children) has the following and who:

Illness	Yes	No	If, yes, please indicate who
1. Mental health disorder			
2. Cancer: Colon, lung, uterine or Other: _____			
3. Breast cancer			
4. Ovarian Cancer			
5. Diabetes			
6. High blood pressure			
7. Heart disease			
8. High cholesterol			
9. Other major health problem			

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PAST/CURRENT HEALTH CONCERNS

Check all boxes that apply to YOU. If yes, please explain below.

Illness	Yes	No	Illness	Yes	No
1. Diabetes			14. D (Rh) Sensitized		
2. Hypertension			15. Pulmonary (TB, Asthma)		
3. Heart Disease			16. Seasonal Allergies		
4. Autoimmune			17. Drug/Latex Allergy		
5. Kidney Disease/UTI			18. Breast		
6. Neurologic/Epilepsy			19. GYN Surgery		
7. Psychiatric			20. Operations/Hospitalizations		
8. Depression/Postpartum			Year/Reason:		
9. Hepatitis/Liver Disease			21. Anesthetic Complications		
10. Varicosities/Phlebitis			22. History of Abnormal Pap smear		
11. Thyroid dysfunction			23. Uterine abnormalities/DES?		
12. Trauma/Violence			24. Infertility/ART Treatment		
13. History of Blood transfusion			25. Relevant Family History		

PREGNANCY HISTORY

Total # Pregnancies	Full Term	Premature	Abortion	Miscarriage	Multiple births	Ectopics	Living

Please detail all pregnancies in order, including miscarriages, molar pregnancies and abortions

#	Month/ Year	Weeks at delivery	Hours in Labor	Baby's Sex & Birth weight	Type of Delivery (Vaginal/C-Section/etc)	Anesthesia	Place of Delivery	Preterm labor?	Comments/ Complications
1				M/F				Yes / No	
2				M/F				Yes / No	
3				M/F				Yes / No	
4				M/F				Yes / No	
5				M/F				Yes / No	
6				M/F				Yes / No	

PRETERM LABOR RISK ASSESSMENT

1. Preterm delivery secondary to Preterm labor or PROM less than 37 weeks last delivery?
2. Preterm labor last pregnancy requiring tocolytics with delivery at term?
3. Uterine anomaly – nullipara (didelphys)