Physicians Surgeons for Women

# OB History Form

Patient Name _____ D.O.B. _____

**New Pregnancy:** Weight before became pregnant _____

Pregnancy Test taken: Y / N Date of Test _____

**Menstrual History**

First Day of Last Menstrual Period (LMP) _____ (approximate date) Normal/Abnormal

Age Periods Began: _____ How often _____ Duration _____

**Pregnancies (Include current pregnancy)**

Total Number of Pregnancies: _____ Number of Live Births: _____

Number of Miscarriages: _____ (include mo/yr) Number of Abortions: _____

Number of Children Living Now: _____ Number of Premature Births <37 weeks) _____

**Delivery Notes:**

| | Birth Date | Weight at Birth | Baby's Sex M/F | Weeks Pregnant | Type of Delivery Vaginal or C- Section | Hospital Where Delivered | Physicians Name | Notes |
|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |

**Medical History**

| HISTORY | Yes/ No | DATE | COMMENT | HISTORY | Yes/ No | DATE | COMMENT |
|---|---|---|---|---|---|---|---|
| Allergic Rhinitis | | | | Liver Disease | | | |
| Anemia/Hematologic | | | | Neurologic Disorder | | | |
| Asthma/ Pulmonary | | | | Renal Disease | | | |
| Autoimmune Disorder | | | | (Rh) Sensitized | | | |
| Abnormal Pap Smear | | | | Thyroid Disorder | | | |
| Blood Transfusions | | | | Trauma History | | | |
| Breast Disorder | | | | Uterine Abnormalities | | | |
| Depression | | | | Varicosities/DVT | | | |
| Psychiatric Disorder | | | | Anesthetic Complications | | | |
| Diabetes | | | | Heart Disease | | | |
| Hypertension/High Blood Pressure | | | | Infertility or **Other** | | | |

| Substance | Yes/No | Amt/Day Pre- Pregnancy | Amt/Day During Pregnancy | # Years Used | Comments |
|---|---|---|---|---|---|

Physicians for Surgeons for Women

| | | | | | |
|---|---|---|---|---|---|
| Tobacco (packs/day) | | | | | |
| Alcohol (drinks/day) | | | | | |
| Illicit Recreational Drugs | | | | | |

| Surgery/ Hospitalizations | Year | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Genetic & Exposure Screening**

| Genetic Screening | Y/N | Comments |
|---|---|---|
| Are you over the age of 35? | | |
| Family history of Spina Bifida, NTD? | | |
| Family History of Down Syndrome? | | |
| Family history of Congenital heart defect | | |
| Family history of Cystic Fibrosis | | |
| Are you of Jewish, Cajun, French Canadian ancestry | | |
| Are you of Italian, Greek, Mediterranean, Asian Ancestry | | |
| Family or personal history of Hemophilia or Hematologic Disease | | |
| Family or personal history of Huntington's Chorea | | |
| Family or personal history of Autism | | |
| If Yes, was the person tested for Fragile X | | |
| Family or personal history of Mental Retardation | | |
| If Yes, was the person tested for Fragile X | | |
| Family or personal history of Muscular Dystrophy | | |
| Family or personal history of Sickle Cell or Trait Disease (African) | | |
| Other Inherited Genetic or Chromosomal Disorder | | |
| Personal history of Diabetes, PKU | | |
| Personal history of Recurrent Pregnancy Loss, or a Stillbirth | | |
| Personal history of other Birth Defects | | |
| Personal history of Other Genetic Screening | | |

| Exposure/Infection History | Y/N | Comments |
|---|---|---|
| Partner has History of HIV | | |
| Patient or Partner has History of Genital Herpes | | |
| Exposure to TB | | |
| Rash or Viral Illness since LMP | | |
| History of Sexually Transmitted Disease | | |
| Did you have Chicken Pox as a child? Or received immunization | | |
| Other Exposure or History of Infection | | |