New OB History Form

(Please Print)

Your Name (Last) _____ (First) _____ (M.I) _____
Date of Birth _____ Referred by _____
Emergency Contact _____ Relationship _____ Phone _____

How may we contact you?				
	Call you at home?	Yes / No	Leave Message?	Yes / No
	Call you at work?	Yes / No	Leave Message?	Yes / No
	Call you on cell?	Yes / No	Leave Message?	Yes / No

Personal Health History

Do you have any known **Allergies**? ☐ Yes ☐ No

Allergic to any of the following (circle those that apply):

Contrast Dye Nickel Peanuts Latex Shellfish Other: _____

Please list **ALL** allergies here and the allergic reaction:

Allergic to	Reaction

Please mark any condition that you have or have had in the past:

Anemia	☐ Yes	☐ No	
Arthritis or Lupus	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Blood Clotting Disorder(e.g. Phlebitis/Thrombophilia)	☐ Yes	☐ No	
Blood Transfusion	☐ Yes	☐ No	
Breast Disease	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Chicken Pox	☐ Yes	☐ No	If no were you vaccinated? ☐ Yes ☐ No

Depression/ Postpartum Depression	☐ Yes	☐ No	
Diabetes (Type 1 or 2)	☐ Yes	☐ No	
Eating Disorder	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Frequent Infections	☐ Yes	☐ No	
Gastrointestinal Illness	☐ Yes	☐ No	
Gestational Diabetes	☐ Yes	☐ No	
Group B Streptococcus in Prior Pregnancy	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Herpes	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
HIV/Aids	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Prior Preterm Birth	☐ Yes	☐ No	
Psychiatric Illness	☐ Yes	☐ No	
Recurrent Urinary Tract Infections	☐ Yes	☐ No	
Sexually Transmitted Infections	☐ Yes	☐ No	
Skin Disorders	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Thyroid Disorder	☐ Yes	☐ No	
Von Willebrand disease or other bleeding disorders	☐ Yes	☐ No	
Other (List):	☐ Yes	☐ No	_____

Please indicate any **surgery or hospitalization** that you have had and the date:

_____

_____

_____

_____
_____

Please describe any **health problems or symptoms** that you are having at this time:

_____
_____
_____
_____
_____

Family Medical History

If **ANY** close relatives of yours – such as Brother, Sister, Parent, Children, Grandparent, Aunt or Uncle (indicate whether maternal or paternal), - has **EVER HAD** or **CURRENTLY HAS** any of the problems listed below, please enter an "X" in the YES column and then enter **specific** relationship to you.

Is your family history known to you? ☐ Yes ☐ No

Endometriosis	☐ Yes	☐ No	Who: _____
Uterine Fibroids	☐ Yes	☐ No	Who: _____
Osteoporosis	☐ Yes	☐ No	Who: _____
Breast Cancer	☐ Yes	☐ No	Who: _____
Ovarian Cancer	☐ Yes	☐ No	Who: _____
Uterine Cancer	☐ Yes	☐ No	Who: _____
Lung Cancer	☐ Yes	☐ No	Who: _____
Colon Cancer	☐ Yes	☐ No	Who: _____
Heart Disease	☐ Yes	☐ No	Who: _____
High Blood Pressure	☐ Yes	☐ No	Who: _____
High Cholesterol	☐ Yes	☐ No	Who: _____

Blood Clots	☐ Yes	☐ No	Who: _____
Bleeding Disorders	☐ Yes	☐ No	Who: _____
Diabetes – Type I	☐ Yes	☐ No	Who: _____
Diabetes – Type II	☐ Yes	☐ No	Who: _____
Hyperthyroidism	☐ Yes	☐ No	Who: _____
Hypothyroidism	☐ Yes	☐ No	Who: _____
Bipolar Disorder	☐ Yes	☐ No	Who: _____
Malignant Tumor	☐ Yes	☐ No	Site & Who: _____
Other Cancer	☐ Yes	☐ No	Type & Who: _____

Do you or any family member have a history of problems with anesthesia? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you have any objections to any form of medical treatment (e.g. blood transfusion)?

☐ Yes ☐ No If yes, please describe: _____

_____

_____

Social History

Occupation: _____ Education level: _____

Marital Status: ☐ Married ☐ Engaged ☐ Living with Significant Other ☐ Separated

☐ Divorced ☐ Single ☐ Widowed ☐ Other _____

Spouse/Partner's name: _____ Spouse/Partner's occupation: _____

Caffeine Use: ☐ Yes ☐ No How Much? _____

Exercise Habits: ☐ Active but no formal exercise

☐ Heavy amount of exercise (4 more times weekly)

☐ Moderate amount of exercise (1-3 times weekly)

☐ Minimal amounts of exercise (Once weekly or less)

☐ Sedentary

Have you ever been abused? ☐ Yes ☐ No

Indicate which: ☐ Emotionally ☐ Physically ☐ Sexually

Have you received counseling for this? ☐ Yes ☐ No

Are you at risk for travel-related illness? ☐ Yes ☐ No Explain: _____

Do you wear your seatbelt? ☐ Yes ☐ No

Military History: ☐ Currently ☐ Previously ☐ Never

Exposures Affecting Health

Do you currently smoke, chew, or use any type of nicotine delivery system (ENDS), or vapor?

☐ Yes ☐ No If yes, how much per day? _____

In the past year? ☐ Yes ☐ No If yes, how much per day? _____

If former smoker/user, when did you quit? _____

Are you exposed to second-hand smoke? ☐ Yes ☐ No

Did you drink alcohol beverages before you became pregnant? ☐ Yes ☐ No

If yes, how many drinks per week? _____

Do you drink alcohol beverages now? ☐ Yes ☐ No If yes, how many drinks per week? ____

What type of drinks? _____

Please list all medications (prescription and other) taken since your last period.

Prescription Medications

Drug Name	Dose	How Often	Start Date	Prescribed By

Primary Pharmacy Name _____ Phone # _____

Over-the-Counter Vitamins, Supplements or Herbs

Product Name	Dose (if known)	How Often	Start Date	Reason

Have you used any street drugs since your last menstrual period (e.g. cocaine, marijuana, opioids)? ☐ Yes ☐ No If yes, indicate number of uses per week: _____

What type of drugs? _____

Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS (this may include a history of blood transfusions, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs)? ☐ Yes ☐ No

Have you been exposed to chemicals (e.g. pesticides, lead, hazardous material/agents) or radiation (e.g. X-rays) since you became pregnant? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are there cats in your home? ☐ Yes ☐ No

Are you on a restricted diet? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Do you have any problems (e.g. job, transportation) that prevent you from keeping your health care appointments? ☐ Yes ☐ No

Do you feel unsafe where you live? ☐ Yes ☐ No

In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?

☐ Yes ☐ No

Has anyone forced you to perform any sexual act that you did not want to do? ☐ Yes ☐ No

On a 1-5 scale, how do you rate your current stress level?

Low 1 2 3 4 5 High

How many times have you moved in the past 12 months? _____

If you could change the timing of this pregnancy, would you want it

____earlier ____later ____not at all ____NA

Have you been involved in any car accidents or had any trauma to your abdomen since your last menstrual cycle? ☐ Yes ☐ No

Gynecologic Health History

Age at first menstrual period: _____

First day of your last menstrual period? _____Are you certain of the date? _____

Cycle interval (28 days or ?) _____ Number of days bleeding with a period? _____

How heavy is the flow? Light Medium Heavy

Do you have pain with periods? _____ Break-through bleeding? _____

Pelvic pain of any other nature? _____

Do you use contraception? _____ If so, what type? _____

When was your last Pap test? _____

Have you received all three doses of the HPV vaccine? ☐ Yes ☐ No

Have you ever had an abnormal Pap test? ☐ Yes ☐ No

If yes, when and how were you treated? _____

_____

What was the diagnosis? _____

Have you ever had HPV? ☐ Yes ☐ No

Have you ever had ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease?

If yes, when, how and where were you treated? _____

_____

Have you ever had herpes? ☐ Yes ☐ No

If yes, where do you have outbreaks? _____

If yes, how often do you have outbreaks? _____

Have you ever had syphilis? ☐ Yes ☐ No

If yes, when, how and where were you treated? _____

_____

Have you ever used an intrauterine device (IUD) for contraception? ☐ Yes ☐ No

If yes, please indicate when: _____

Did you have any problems with the IUD? ☐ Yes ☐ No If yes, please describe: _____

_____

Have you been treated for infertility? ☐ Yes ☐ No

If yes, please describe when and treatment received: _____

_____

_____

_____

Do you have any other concerns related to your past health history? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

Obstetric Medical History

Pregnancy Summary (Total number including current pregnancy)

Total Number of Pregnancies	Full Term Births (>37 wks)	Premature Births (<37 wks)	Terminations	Miscarriages- Was Surgery Needed?	Ectopic pregnancies Left or Right?	Multiple Births	Stillbirths	Number of Living Children

Please provide dates of terminations, miscarriages and ectopic pregnancies.

Comments: _____
_____
_____
_____

Pregnancy Details

(Include miscarriages, ectopics and terminations in the sequence):

Child's Birthdate MM/DD/YY	Child's Name	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S + C/S type)	Anest-hesia	Complications/Problems	Physician	Location

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Child's Birthdate MM/DD/YY	Child's Name	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S + C/S type)	Anest-hesia	Complications/Problems	Physician	Location

Family History & Genetic Screening

What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

Have either you or has the baby's father had a child with a birth defect? ☐ Yes ☐ No

If yes, please describe: _____

Did either you or the baby's father have a birth defect? ☐ Yes ☐ No

If yes, please describe: _____

Please describe any special needs that have occurred in children of your family or the baby's father's family (e.g. cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):

_____

_____

_____

How is this child/person related to you? _____

Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)? ☐ Yes ☐ No

If yes, have either of you had genetic counseling? ☐ Yes ☐ No

If yes, have either of you had chromosomal testing? ☐ Yes ☐ No

Where and what were the results? _____

_____

_____

Some genetic problems occur more in couples with certain racial or ancestral backgrounds.

Please check if you are, or the baby's father is, of one of these backgrounds:

Eastern European Jewish (Ashkenazi) Ancestry ☐ Yes ☐ No

If yes, have you had Tay-Sachs screening test? ☐ Yes ☐ No

If yes, have you had a Canavan screening test? ☐ Yes ☐ No

If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No

Date: ____/____/____ Results: _____

African American ☐ Yes ☐ No

If yes, have you had sickle cell screening? ☐ Yes ☐ No

Date: ____/____/____ Results: _____

Mediterranean Ancestry or Southeast Asian Ancestry ☐ Yes ☐ No

If yes, have you had screening for inherited forms of anemia such as Thalassemia?

☐ Yes ☐ No

Date: ____/____/____ Results: _____

French Canadian or Cajun Ancestry ☐ Yes ☐ No

If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No

Date: ____/____/____ Results: _____

Have you had cystic fibrosis screening? ☐ Yes ☐ No

Have you had any other genetic carrier screening, such as an expanded carrier screening?

☐ Yes ☐ No

Screening: _____ Date: ____/____/____ Result: _____

Please list any other concerns you have about birth defects or inherited disorders:

_____

_____

_____

Do you want a test that will tell you about your risk to have a baby with chromosomal abnormalities such as Down syndrome? ☐ Yes ☐ No

I attest that the information here is true and correct to the best of my belief.

_____

Patient Signature

_____

Print Name

_____

Date

Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

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