



Obstetrical History Form
Obstetrics & Gynecology
Ver 032026

Name: _____ Age: _____ Date: _____
First Middle Last

Date of Birth: _____ Occupation: _____

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

Father's DOB: _____ Name of Father of the baby: _____

Father's Age: _____ Ethnicity of Father: _____

Please list all the medications you are currently taking:

Please list all allergies to medications/Latex/Iodine/foods:

When was the **first** day of your last period: _____ ☐ Unknown

Past Obstetrical History (List all pregnancies including miscarriages, abortions, tubal/ectopic)

Date	Length of Pregnancy	D&C	Vaginal or C-Section	Girl or Boy	Weight	Complications	Delivery Doctor	Place of Delivery	Hours of Labor

Name _____ Date of Birth _____

Past Medical History

Have you ever been diagnosed with any of the following? (Check if yes)

- | | |
|---|---|
| ☐ Diabetes | ☐ Infertility |
| ☐ High Blood Pressure | ☐ Asthma/TB |
| ☐ Kidney Disease | ☐ Uterine anomaly |
| ☐ Epilepsy/Seizures | ☐ Rh Isoimmunization |
| ☐ Heart Disease/Murmur | ☐ Neurologic Disorder (ex, MS) |
| ☐ Hypothyroid/Hyperthyroid | ☐ Liver Disease/ |
| ☐ Lupus/Rheumatoid Arthritis/Sjogrens | ☐ Hepatitis A, B, C |
| ☐ Deep Vein Thrombosis/Pulmonary Embolus: _____ | |
| ☐ Recurrent urinary tract infections/pyelo/stones: _____ | |
| ☐ Psychiatric Disorder/Anxiety/Depression/Bipolar: _____ | |
| ☐ Bleeding Disorder (Von Willebrand/Hemophilia): _____ | |
| ☐ Preeclampsia: _____ | |

Have you ever had a blood transfusion? ☐ Yes ☐ No

Why? _____

Would you accept a blood transfusion if needed in case of emergency? ☐ Yes ☐ No

Gynecologic History

Do you normally have a period every month? ☐ Yes ☐ No Every ____ days

Have you had any bleeding since your last period? ☐ Yes ☐ No

What day was your pregnancy test first positive?

Were you on birth control when you got pregnant? ☐ Yes ☐ No

Average cycle length? _____ Age of first period? _____

When was your most recent pap smear? _____ Results? _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

When? _____ Any treatment or biopsy? _____

Have you ever had:

- | | |
|--|--|
| ☐ Herpes | ☐ Syphilis |
| ☐ Chlamydia | ☐ HIV/AIDS |
| ☐ Gonorrhea | ☐ Hepatitis A/B/C |
| ☐ HPV/Genital warts | ☐ Trichomonas |
| ☐ Pelvic inflammatory disease | |

Do you have concerns regarding your bladder? _____

Name _____ Date of Birth _____

Surgeries and Hospitalizations (Use a separate piece of paper if more space is needed)

Surgery/Hospitalization	Date	Reason/Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Relationship	Age	Age at Death	Medical conditions
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Spouse			

Does anyone in your family have Breast Cancer? ☐ Yes ☐ No Who?

Does anyone in your family have Ovarian Cancer? ☐ Yes ☐ No Who?

Does anyone in your family have Colon Cancer? ☐ Yes ☐ No Who?

Does anyone in your family have Osteopenia? ☐ Yes ☐ No Who?

Does anyone in your family have DVT or PE history? ☐ Yes ☐ No Who?

Name _____ Date of Birth _____

Was anyone in your family or the father of the baby's family born with any of the following?

Tay-Sachs	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Canavan Disease	☐ Yes	☐ No
Down Syndrome	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Huntington's Chorea	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Sickle Cell Disease/Trait	☐ Yes	☐ No
Spina Bifida/Anencephaly	☐ Yes	☐ No
Intellectual Disability/Autism	☐ Yes	☐ No
Other inherited chromosomal/genetic disorder	☐ Yes	☐ No
Recurrent pregnancy loss or stillbirth	☐ Yes	☐ No
Metabolic Disorder (insulin dependent diabetes, PKU)	☐ Yes	☐ No

Are you Ashkenazi Jewish?	☐ Yes	☐ No
Do you eat fish on a regular basis?	☐ Yes	☐ No
Do you plan to get an epidural during labor?	☐ Yes	☐ No
Do you plan to have your baby circumcised if it is a male?	☐ Yes	☐ No
Do you plan to breast feed?	☐ Yes	☐ No

Have you had the vaccine for Hepatitis B?	☐ Yes	☐ No
Have you had the chicken pox or the Chicken pox vaccine?	☐ Yes	☐ No
Have you been exposed to or tested positive to Tuberculosis?	☐ Yes	☐ No
Are you planning on getting your tubes tied?	☐ Yes	☐ No
Have you or any family members had any major reactions to general anesthesia? If yes, explain:	☐ Yes	☐ No

Name _____ Date of Birth _____

Social History:

Do you Smoke? ☐ Yes ☐ No

How much before pregnancy? _____

Packs/Per Day

How much since you found out you were pregnant? _____

Packs/Per Day

Do you drink alcohol? ☐ Yes ☐ No

How much before pregnancy? _____

Drinks/Per Week

How much since you found out you were pregnant? _____

Drinks/Per Week

Do you use any drugs? ☐ Yes ☐ No

How much before pregnancy? _____

How much since you found out you were pregnant? _____

What drugs do you regularly use? _____

Have you ever used IV drugs? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No Servings per day? _____

Do you own cats? ☐ Yes ☐ No Who normally cares for the litter box? _____

Within the past year or since becoming pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No

Are you in a relationship with someone who threatens you or physically hurts you? ☐ Yes ☐ No

Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION:

Provider signature: Reviewed with patient: _____ Date: _____