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
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Epilepsy/Seizures
- ☐ Heart Disease/Murmur
- ☐ Hypothyroid/Hyperthyroid
- ☐ Lupus/Rheumatoid Arthritis/Sjogrens
- ☐ Infertility
- ☐ Asthma/TB
- ☐ Uterine anomaly
- ☐ Rh Isoimmunization
- ☐ Neurologic Disorder (ex, MS)
- ☐ Liver Disease/
- ☐ 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
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ HPV/Genital warts
- ☐ Pelvic inflammatory disease
- ☐ Syphilis
- ☐ HIV/AIDS
- ☐ Hepatitis A/B/C
- ☐ Trichomonas

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: