Obstetrical History Form
Obstetrics & Gynecology
Ver 20220804

Name: ____ Date: ______________
First Middle Last

Age: ______ Date of Birth: _________ Occupation: ________________________

Please list all medications you are currently taking:

____
____
____
____
____
____

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

____
____
____
____
____
____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Father's DOB: _______ Name of Father of the baby: _______________________

Age: ____ Ethnicity of Father: ______________________________

Patient Name: ______________________________________DOB: __________

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

Surgery/Hospitalization	Date	Reason/Diagnosis

Family History

Relation	Age	Age at Death	Medical Conditions

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

Patient Name: ________________________________ **DOB:** _______________

Family History (continued)

Do you use any drugs? ☐ Yes ☐ No

How much before pregnancy? ____

How much before you found out you were pregnant? ______________________

What drugs do you regularly use? ________________________________

Have you ever used IV drugs? ☐ Yes ☐ No

Past Medical History

Have you ever been diagnosed with any of the following?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Epilepsy/Seizures
- ☐ Heart Disease/Murmur
- ☐ Hypothyroid/Hyperthyroid
- ☐ Lupus/Rheumatoid Arthritis/Sjogren
- ☐ Blood Clots/DVT/Pulmonary Embolus
- ☐ Recurrent urinary tract infections/pyelo/stones
- ☐ Psychiatric Disorder/Anxiety/Depression/Bipolar
- ☐ Bleeding Disorder (Von Willebrands/Hemophilia
- ☐ Infertility
- ☐ Asthma/TB
- ☐ Uterine anomaly
- ☐ Rh Isoimmunization
- ☐ Neurologic Disorder (ex, MS)
- ☐ Liver Disease/ Hepatitis A, B, C

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

Why?

____

Patient Name: ________________________________ DOB: _______________

Please list any other pertinent medical Information

____
____
____
____

Gynecologic History

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

When? ____

What treatment was done? ____

When was your most recent pap smear? ________________________________

Results? ____

Have you ever had:

☐ Herpes

☐ Chlamydia

☐ Gonorrhea

☐ HPV/Genital warts

☐ Syphilis

☐ HIV/AIDS

☐ Hepatitis A/B/C

☐ Pelvic inflammatory disease

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

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

Patient Name: _________________________________ DOB: _______________

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

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
Mental Retardation/Autism	☐ Yes	☐ No
Other inherited chromosomal/genetic disorder	☐ Yes	☐ No
Recurrent pregnancy loss or stillbirth	☐ Yes	☐ No
Maternal metabolic disorder (insulin dependent diabetes, PKU)	☐ Yes	☐ No
Are you Ashkenazi Jewish?	☐ Yes	☐ No

When was the last day of your period? _________________________________

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? _________

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

Do you own cats? ☐Yes ☐ No

Patient Name: ________________________________ DOB: ____________

Who normally cares for the litter box? _________________

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

Are you planning on getting your tubes tied? ☐ Yes ☐ No

Have you had the vaccine for Hepatitis B? ☐ Yes ☐ No

Have you been exposed to or ever tested positive for TB (Tuberculosis)?
☐ Yes ☐ No

Have you had the chicken pox? ☐ Yes ☐ No

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

Have you or anyone in your family ever had any major problems with anesthesia?
☐ Yes ☐ No

Explain: ____

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

Patient Name: ________________________________ DOB: _____________

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION:

____

____

____

____

____

____

____

____

____

____

____

____

____

Reviewed with patient: __________________________ Date: _______________