NEW OB MEDICAL INFORMATION

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NAME: _____ AGE: _____ DOB: _____

SPOUSE OR CONTACT PERSON: _____ RELATIONSHIP: _____ PHONE #: _____

DATE OF LAST PERIOD:_____ # PREGNANCIES: _____ # CHILDREN: _____ # MISCARRIAGES: _____ # ECTOPICS: _____

DATE	GENDER	NAME	WEIGHT	VAGINAL	CESAREAN	GEST. AGE	COMPLICATION	HOURS IN LABOR	HOSPITAL
__/__/__	☐M ☐F	_____	_____	☐	☐	_____	_____	_____	_____
__/__/__	☐M ☐F	_____	_____	☐	☐	_____	_____	_____	_____
__/__/__	☐M ☐F	_____	_____	☐	☐	_____	_____	_____	_____
__/__/__	☐M ☐F	_____	_____	☐	☐	_____	_____	_____	_____

OPERATIONS	YEAR	OTHER HOSPITALIZATIONS	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES: _____

PRESENT MEDICATIONS: _____

HAVE YOU EVER HAD:

	NO	YES		NO	YES
ANEMIA	☐	☐	KIDNEY DISEASE	☐	☐
HIGH BLOOD PRESSURE	☐	☐	URINARY INFECTIONS	☐	☐
DIABETES	☐	☐	TRANSFUSIONS	☐	☐
HEART DISEASE	☐	☐	HERPES VIRUS	☐	☐
HEART MURMUR	☐	☐	INFERTILITY IVF	☐	☐
AUTOIMMUNE DISEASE	☐	☐	SURGERY ON CERVIX	☐	☐

	No	Yes		No	Yes
Tuberculosis	☐	☐	Asthma or Lung Disease	☐	☐
Sickle Cell Disease	☐	☐	Blood clot/DVT	☐	☐
Uterine Anomaly	☐	☐	Gall Bladder Disease	☐	☐
Migraine Headaches	☐	☐	Cancer	☐	☐
Hepatitis	☐	☐	HIV	☐	☐
Thyroid Disease	☐	☐	Depression	☐	☐
Seizures/epilepsy	☐	☐	Rh(D) sensitized	☐	☐

Family History: Have you or any relative (including father and his family) ever had:

	No	Yes		No	Yes
Diabetes	☐	☐	Tay Sachs	☐	☐
Heart Disease	☐	☐	Huntington Chorea	☐	☐
Heart Attack	☐	☐	Ashkenazi background	☐	☐
Stroke	☐	☐	Canavan Disease	☐	☐
High Blood Pressure	☐	☐	Familial Dysautonomia	☐	☐
Cystic Fibrosis	☐	☐	Sickle Cell Disease	☐	☐
Recurrent Preg loss	☐	☐	Hemophilia	☐	☐
Thalassemia	☐	☐	Muscular Dystrophy	☐	☐
Spina Bifida	☐	☐	Mental Retardation	☐	☐
Congenital Heart Defect	☐	☐	Fragile X Syndrome	☐	☐
Down Syndrome	☐	☐			

Completed By: _____

Reviewed with patient by: Physicians Signature:_____ Date:_____