

Obstetric Medical History

Part A - General Information

Today's Date: _____

Last Name	First Name	Age	Date of Birth	Referred by:	I was referred by a(n):
Emergency Contact Name (State Relationship)	Emergency Contact Number	Healthcare Provider Name (i.e. Midwife):			<input type="checkbox"/> Obstetrician <input type="checkbox"/> Mid-Wife <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Family Doctor <input type="checkbox"/> Other: _____

<p>What was the first day of your last menstrual period (LMP)? _____</p> <p>Was the period: <input type="checkbox"/> NORMAL or <input type="checkbox"/> ABNORMAL? Are you: <input type="checkbox"/> CERTAIN or <input type="checkbox"/> UNCERTAIN of this date?</p> <p>If UNCERTAIN what is your estimated due date (EDD)? _____</p> <p>_____ How many times have you been pregnant (include current pregnancy)? _____ How many full-term births? _____ How many pre-term births? _____ How many miscarriages or abortions? _____ How many children living?</p>	<p>Have you had any of the following surgical procedures?</p> <p>Tubal Surgery: Y / N (If YES, Date: _____)</p> <p>Laparoscopy: Y / N (If YES, Date: _____)</p> <p>D & C: Y / N (If YES, Date: _____)</p> <p>Gall Bladder Removal: Y / N (If YES, Date: _____)</p> <p>Appendix Removal: Y / N (If YES, Date: _____)</p> <p>Any other surgery: Y / N (If YES, Date: _____)</p>
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Part B - Please list all past pregnancies:

PREGNANCY NUMBER	DATE	WEEKS PREGNANT	VAGINAL OR C-SECTION	SEX OF BABY	WEIGHT OF BABY	COMPLICATIONS
1						
2						
3						
4						

Part C - Are you currently participating in any of the following?

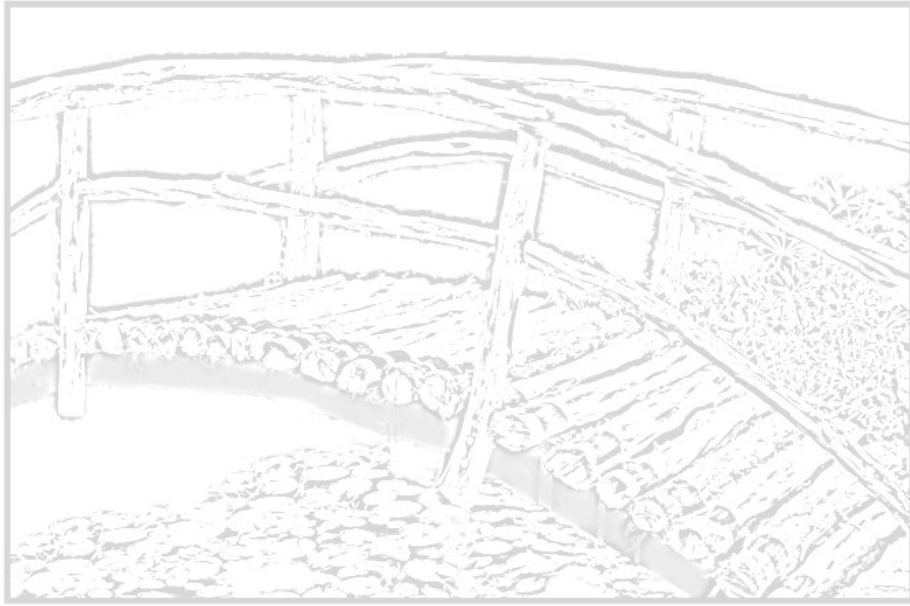
YES	NO	QUESTION	ANSWER
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SMOKE TOBACCO?	IF YES, HOW MUCH? _____ CIGARETTES / PACKS (CIRCLE ONE) PER DAY
<input type="checkbox"/>	<input type="checkbox"/>	DID YOU SMOKE PRIOR TO BECOMING PREGNANT AND QUIT?	IF YES, WHEN DID YOU QUIT? _____
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU DRINK ALCOHOLIC BEVERAGES?	IF YES, HOW MANY DRINKS PER WEEK?
<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER USED MARIJUANA, SPEED, COCAINE, HEROIN, CRACK, LSD, ACID OR OTHER MIND-ALTERING DRUGS?	

Part D - During this pregnancy, have you experienced any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS.
<input type="checkbox"/>	<input type="checkbox"/>	NAUSEA OR VOMITING?	
<input type="checkbox"/>	<input type="checkbox"/>	VAGINAL BLEEDING?	
<input type="checkbox"/>	<input type="checkbox"/>	PAINFUL URINATION?	
<input type="checkbox"/>	<input type="checkbox"/>	ABDOMINAL PAIN?	
<input type="checkbox"/>	<input type="checkbox"/>	FLU, COLD, MEASLES, CHICKENPOX, OR OTHER ILLNESS?	
<input type="checkbox"/>	<input type="checkbox"/>	X-RAYS?	
<input type="checkbox"/>	<input type="checkbox"/>	TAKEN ANY MEDICATION? (ASPIRIN, ANTIBIOTICS, ETC.)	

Part E - During PREVIOUS pregnancies, did you experience any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS OR CONDITIONS NOT LISTED
<input type="checkbox"/>	<input type="checkbox"/>	A STILLBORN BABY?	
<input type="checkbox"/>	<input type="checkbox"/>	A BIRTH DEFECT OR ABNORMALITY?	
<input type="checkbox"/>	<input type="checkbox"/>	INFANT DEATH FOLLOWING DELIVERY?	
<input type="checkbox"/>	<input type="checkbox"/>	A PREMATURE BABY?	
<input type="checkbox"/>	<input type="checkbox"/>	A BABY WITH A SERIOUS INFECTION?	
<input type="checkbox"/>	<input type="checkbox"/>	A BABY ADMITTED TO THE INTENSIVE CARE UNIT?	
<input type="checkbox"/>	<input type="checkbox"/>	A BABY WITH JAUNDICE	
<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE BLEEDING (HEMORRHAGE) AFTER DELIVERY?	
<input type="checkbox"/>	<input type="checkbox"/>	HOSPITALIZATION BEFORE LABOR?	
<input type="checkbox"/>	<input type="checkbox"/>	RHOGAM INJECTIONS	



*Central Family
Practice*