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OB PATIENT HISTORY

Date: _____

Name: _____ **Date of birth:** _____ **Partner**: _____

Date of Last Period (first day): _____ ☐ sure ☐ unsure **Date of 1st positive home pregnancy test:** _____

Menarche (age onset): _____years **Menstrual frequency:** ☐ regular (every ____ days) ☐ irregular **Duration:** ____days

Baseline weight: _____lbs

Past Pregnancy history:

Date	GA*	Birth weight	Sex (M/F)	Vaginal or C section	Epidural (Y/N)	Location	Complications with pregnancy, delivery, and/or postpartum

*GA=number of weeks pregnant at time of delivery (40 weeks=due date)

List any additional pregnancies: _____

	Y/N	Notes		Y/N	Notes
Patient's Age Will Be 35 Years Or Older At Estimated Date of Delivery			Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)		
Thalassemia (Italian, Greek, Mediterranean, Or Asian Background): MCV < 80			Patient Or Baby's Father Had A Child With Birth Defects Not Listed Above		
Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly)			Recurrent Pregnancy Loss, Or A Stillbirth		
Congenital Heart Defect			Medications (including Supplements, Vitamins, Herbs, OTC Drugs), Illicit/Recreational Drugs, Alcohol		
Down Syndrome			If Yes, Agent(s) And Strength/Dosage		
Tay-Sachs (eg, Jewish, Cajun, French-Canadian)			Any Other Genetic History		
Canavan Disease			Live With Someone With TB Or Exposed To TB		
Sickle Cell Disease Or Trait (African)			Patient Or Partner Has History Of Genital Herpes		
Hemophilia Or Other Blood Disorders			Rash Or Viral Illness Since Last Menstrual Period		
Muscular Dystrophy			Prior GBS-infected child		
Cystic Fibrosis			History Of STD, Gonorrhea, Chlamydia, HPV, Syphilis		
Huntington's Chorea			Other Infection History		
Mental Retardation/Autism			History of HIV		
If Yes, Was Person Tested For Fragile X?			History of Hepatitis		
Other Inherited Genetic Or Chromosomal Disorder					

Exposure/infection history:

Chicken pox history: ☐ Prior natural infection ☐ Prior vaccination ☐ Neither
Recent travel outside of the country (within the past 6 mon: ☐ No ☐ Yes, please list location(s): _____

Allergies (medications, latex): ☐none

_____

Medications: _____
_____
_____

Delivery plans (if known):
Type of delivery: ☐ Vaginal ☐ C section ☐ VBAC
Anesthesia: ☐ None ☐ Epidural ☐ Other
Tubal ligation: ☐ Yes ☐ No
- If no, plan for birth control? ☐ Yes _____ ☐ None
Circumcision (if boy): ☐ Yes ☐ No
Feeding: ☐ Formula ☐ Breast
Blood transfusion acceptable in an emergency situation: ☐ Yes ☐ No

Pediatrician: _____

Hospital: _____