CHENA *Obstetrics & Gynecology*

OB History Form

Today's Date: _____

Patient Name: _____DOB: _____ Age: _____

Race: _____ Marital Status: □Single □Married □ Other_____

Occupation: _____ Father of the Baby: _____

Emergency Contact: _____ Contact #:_____

Menstrual History

1st day of your last menstrual period (LMP):_____

Are you sure about your LMP: □ Definite □Unsure

Prior to becoming pregnant were your periods monthly: □ Yes □ No

Were you taking birth control when you became pregnant: □ Yes Type: _____ □ No

When was your first positive pregnancy test: _____

Past Pregnancies

Total Pregnancies (Including Current)	Full Term	Premature (Before 37wks)	Elective Abortion	Miscarriage	Ectopic	Multiple Births	Living

Date Month/ Year	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Epidural	Place of Delivery	Preterm Labor Y/N	Comments/ Complications

Infection History

Living with someone with TB or exposed to TB	**YES or NO**	Hepatitis B or C	**YES or NO**
Personal history of or partner with history of genital herpes	**YES or NO**	History of STD Type:	**YES or NO**
Rash or viral illness since LMP	**YES or NO**	History of MRSA	**YES or NO**
History of Chicken Pox	**YES or NO**		

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Medical History

	Y or N		Y or N
Diabetes		RH Sensitized	
Hypertension		Pulmonary (TB, Asthma)	
Heart Disease		Drug/Latex Allergies/Reactions	
Auto-Immune Disorder		Seasonal Allergies	
Kidney Disease/UTI		Breast Issues	
Neurologic/Epilepsy		GYN Surgery	
Psychiatric Illness /Depression Postpartum Depression		Operations/Hospitalizations Year/Type:	
Hepatitis/Liver Disease		Anesthetic Complications	
History of Blood Clot/Clotting Disorder		History of Abnormal Pap	
Thyroid Dysfunction		**Last pap:** Where:	
Trauma/Violence		Uterine Anomaly/DES	
History of Blood Transfusion		Infertility/Reproductive Treatments	
Tobacco		**Other Family History:**	
Illicit/Recreational Drugs			
Family history of Breast, Uterine, Ovarian or Colon Cancers		**Current Medications (Including Vitamins):**	

If you have marked yes on any of the above conditions, please explain: _____

_____

_____

Genetic Screening/History

Please include your history as well as baby's father (FOB) and other blood related family members

	Y or N		Y or N
Your age 35yrs or older as of Estimated Due Date		Huntington's Chorea	
Thalassemia (Italian, Greek, Mediterranean or Asian background)		Mental Retardations/Autism	
Neural Tube Defect		Was this person tested for Fragile X?	
Congenital Heart Defect		Other inherited Genetic or Chromosomal Abnormality	
Down Syndrome		Maternal Metabolic Disorder (Diabetes, PKU, EG)	
Tay-Sachs, Canavan Disease, Familial Dysautonomis (Ashkenazi Jewish)		Patient or FOB had child with birth defects not listed	
Sickle Cell Disease or Trait (African)		Recurrent Pregnancy loss or stillbirth	
Hemophilia/Blood Disorders		Medications (including vitamins or supplements), Illicit drugs/Alcohol since LMP If so what type:	
Muscular Dystrophy			
Cystic Fibrosis/CF Carrier			