OB PATIENT FORM Last Menstrual Period (LMP):

Date:Patient's Name	DOB:		
PAST OBSTETRICAL HIST	ORY		
	YES	NO	
Was your last period normal?			
Are your periods normally every 28-30 days?			
Do you have uterine abnormalities (fibroids, septum, double uterus)?			
Have you tried to get pregnant for 12 months or longer without success?			
Have you ever had a tubal or ectopic pregnancy?			
If you have been pregnant in the past, did you have:			
Gestational diabetes?			
Pre-eclampsia? (Toxemia)			
High blood pressure?			
Caesarean section?			
Baby's shoulders got stuck during a vaginal delivery?			
Post-partum bleeding?			
Cervical incompetence? (Painless opening of the cervix before 24			
wks)			
Preterm labor or delivery?			
PAST INFECTIONS			
	YES	NO	
Have you or your partner ever had:			
HIV			
Hepatitis B			
TB (tuberculosis)			
Herpes (HSV)			
Venereal warts (HPV)			
Syphilis			
Chlamydia			
Gonorrhea			
CMV			
Fifth's Disease (Parvo virus)			
Measles (Rubella)			
German Measles (Rubeola)			
Chickenpox (Varicella)			
Lyme's Disease			
Epstein-Barr (mono)			
Toxoplasmosis			

Other: (please list)

	M/D/	Gender	Weight	Number	Hours	Type of	and abo	Doctor/M	idwife	Name	Complications
	Y			of Weeks	in Labor	Delivery	of Delivery	who deliv	ered	of Child	
1											
2											
3											
4											
5											
6											
7											
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				en the ba	aby is c			RY			
				en the ba	aby is c	lue?		RY			
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Patient's Name:_____

_DOB:____

Patient's Name:	DOB:	
Have you or the baby's father ever had a child born	dead or	
survive birth with a birth defect on listed?		
Are you and the baby's father related by blood?		
Have you taken any prescription drugs, recreational	drugs, or	
herbal supplements just prior to or during this pregn	ancy?	
If so, what medication and how often and for what r	eason?	
Please list:		
Has the baby's father taken any prescription drugs, i	recreational	
drugs, or herbal supplements just prior to or around		
drugs, or nerour supprements just prior to or uround	conception.	
If so, what medication and how often and for what r	eason?	
Please list:		

GENETIC HISTORY

Please place an "X" if any apply:

	Yourself	Partner	Children	Your blood relative	Partner's blood relative	None	Explain
Down's Syndrome							
Neural tube defects							
(spina bifida,							
anencephaly)							
Cystic fibrosis							
Hemophilia							
Huntington's							
chorea							
Muscular							
dystrophy							
Mental retardation							
Tay-Sachs/							
Canavans							
Thalassemia							
Sickle cell anemia							
Autism							
Congenital heart							
defect							