OBSTETRIC HISTORY

Date of Service ____________ Reason for Visit Today ____________

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (< 37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ECT.)
1					
2					
3					
4					
5					

For additional pregnancies continue to back of the form

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES IN PREGNANCY ☐ HYPERTENSION/HIGH BP IN PREGANCY ☐ PRE-ECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGANCY? IF YES, HOW TREATED? ☐ IVF PREGNANCY

CURRENT MEDICATIONS

(Include hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

PAST MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	DIABETES (not related to pregnancy)	☐	☐	TRAUMA/DOMESTIC VIOLENCE
☐	☐	HYPERTENSION (not related to pregnancy)	☐	☐	HISTORY OF BLOOD TRANSFUSION
☐	☐	HEART DISEASE	☐	☐	PULMONARY TB ASTHMA
☐	☐	AUTO-IMMUNE DISORDER	☐	☐	ALLERGIES (DRUGS)
☐	☐	KIDNEY DISEASE	☐	☐	BREAST DISEASE/SURGERY/CANCER
☐	☐	NEUROLOGIC/EPILEPSY	☐	☐	GYN SURGERY
☐	☐	PSYCHIATRIC	☐	☐	SURGERIES/HOSPITALIZATION (YEAR & REASON)
☐	☐	HEPATITIS/LIVER DISEASE	☐	☐	UTERINE ABNORMALITIES
☐	☐	VARICOSITIES/PHLEBITIES	☐	☐	INFERTILITY
☐	☐	THYROID DYSFUNCTION	☐	☐	VAPING/TOBACCO/STREET DRUGS/ALCOHOL

IF YES, EXPLAIN ____________

FAMILY HISTORY

YES	NO		YES	NO	
☐	☐	THALASSEMIA (ITALIAN, GREEK MEDITERRANEAN, OR ASIAN BACKGROUND) MCV-80	☐	☐	CYSTIC FIBROSIS
☐	☐	NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, ORANENCEPHALY)	☐	☐	INTELLECTUAL DISABILITIES, LEARNING DISABILITIES, AUTISM
☐	☐	CONGENITAL HEART DEFECT	☐	☐	OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER
☐	☐	DOWN SYNDROME	☐	☐	MATERNAL METABOLIC DISORDER (INSULIN DEPENDENT DIABETES, PKU)
☐	☐	TAY-SACHS (JEWISH, CAJUN, FRENCH-CANADIAN)	☐	☐	PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE
☐	☐	SICKLE CELL DISEASE OR TRAIT (AFRICAN)	☐	☐	RECURRENT PREGNANCY LOSS OR STILL BORN
☐	☐	HEMOPHILIA	☐	☐	CHILD BORN ALIVE THAT DIED
☐	☐	MUSCULAR DYSTROPHY			

IF YES, EXPLAIN ____________

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ECT.)
6					
7					
8					
9					
10					