

Established Patient OB Form

Name _____ Age _____ DOB ____/____/____ Date ____/____/____

PAST MEDICAL HISTORY:

Since your last visit have you been diagnosed with any new HEALTH PROBLEMS? YES NO
 If YES, please describe: _____

PAST SURGICAL HISTORY:

Have you had any recent SURGERIES? YES NO
 If YES, please describe: _____

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis, including any you discontinued for the pregnancy:

Medication	Dose	Medication	Dose
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Please list all OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS (including prenatal) that you take on a regular basis. Please note any you discontinued for the pregnancy.

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

ALLERGIES:

Have you developed any new ALLERGIES TO MEDICATIONS? YES NO
 If YES, list name of drug and reaction: _____

FAMILY HISTORY:

Have there been any CHANGES in your FAMILY HISTORY? YES NO
 If YES, please note changes:

M= Mother **F**= Father **S**= Sister **B**= Brother **MGM**= Maternal grandmother **MGF**= Maternal grandfather
PGM= Paternal grandmother **PGF**= Paternal grandfather

- | | | | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| 1. High blood pressure | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 2. Diabetes | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 3. Heart disease | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 4. Breast cancer | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 5. Ovarian cancer | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 6. Colon cancer | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 7. Thyroid disorder | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 8. Osteoporosis | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 9. Blood clotting disorder | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 10. Deep venous thrombosis
(DVT – blood clot deep in leg) | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 11. Autoimmune disorders
(such as lupus, rheumatoid arthritis, etc) | <input type="checkbox"/> M | <input type="checkbox"/> F | <input type="checkbox"/> S | <input type="checkbox"/> B | <input type="checkbox"/> MGM | <input type="checkbox"/> MGF | <input type="checkbox"/> PGM | <input type="checkbox"/> PGF |
| 12. Other _____ | | | | | | | | |



MENSTRUAL HISTORY:

Describe your periods before your pregnancy:

- When was your LAST MENSTRUAL PERIOD? _____
- Were your periods REGULAR or IRREGULAR?
- How many DAYS were there BETWEEN your cycles? _____
- How many DAYS did your periods LAST? _____
- Were your periods: LIGHT MODERATE HEAVY CLOTS
- Did you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None MILD MODERATE SEVERE _____

SOCIAL HISTORY:

Before your pregnancy did you drink ALCOHOL? Rarely Occasionally Daily Never _____

Do you smoke? YES NO

If YES, check any that apply: CIGARETTES VAPING E-CIGARETTES MARIJUANA

Do you use any ILLICIT SUBSTANCES? YES NO _____

Are you MARRIED SINGLE WIDOWED DIVORCED SEPARATED?

Do you EXERCISE? Regularly Occasionally Never

Are you EMPLOYED outside the home? YES NO

If YES, what type of work do you do (if you are a student please include this information as well)?

What is the name of the FATHER of your baby? _____ What is his OCCUPATION? _____

Have you ever been a victim of DOMESTIC VIOLENCE? YES NO

Do you wear a SEAT BELT in the car? YES NO

Do you have a RELIGIOUS PREFERENCE? YES NO If YES, what? _____

REVIEW OF SYSTEMS:

Please check any SIGNIFICANT SYMPTOMS you currently experience: NONE

- **CONSTITUTIONAL:** weight gain weight loss fatigue loss of appetite fevers chills other _____
- **EYES:** blurred vision eye pain discharge from eye other _____
- **HEAD & NECK:** severe headaches sore throat nasal discharge nose bleeds decreased hearing
 lightheadedness other _____
- **BREAST:** lumps tenderness nipple discharge other _____
- **CARDIOVASCULAR:** chest pain irregular heartbeat fainting spells other _____
- **RESPIRATORY:** shortness of breath cough wheezing other _____
- **GASTROINTESTINAL:** nausea vomiting diarrhea constipation heartburn abdominal pain
 blood in stools incontinence of stools hemorrhoids other _____
- **GENITOURINARY:** urinary frequency pain with urination blood in urine urinary incontinence difficulty urinating
 vaginal discharge pain with intercourse bleeding with intercourse significant PMS
 other _____
- **SKIN:** rash itching acne abnormal hair growth other _____
- **NEURO:** headaches weakness numbness other _____
- **MUSCULOSKELETAL:** joint pain joint swelling muscle weakness muscle pain other _____
- **ENDOCRINE:** increased thirst increased urination hair loss heat intolerance cold intolerance
 other _____
- **PSYCHIATRIC:** anxiety depression confusion other _____
- **HEMATOLOGIC:** easy bruising easy bleeding lymph node enlargement other _____
- **ALLERGIC:** sinus allergies skin allergies other _____

GENETIC SCREENING:

Will you be 35 YEARS OLD or older when the baby is due? YES NO

Do YOU or the FATHER of your baby, or anyone in YOUR FAMILY, or the baby's FATHER'S FAMILY have the following?

- Thalassemia YES NO
- Italian, Greek, Mediterranean, or Asian background YES NO
- Neural tube defect (meningomyelocele, spina bifida, anencephaly) YES NO
- Congenital heart defect YES NO
- Down syndrome YES NO
- Tay Sachs disease YES NO
- Eastern European Jewish or French-Canadian background YES NO
- Canavan disease YES NO
- Sickle cell disease or trait YES NO
- Hemophilia or other blood disorder YES NO
- Muscular dystrophy YES NO
- Cystic fibrosis YES NO
- Huntington's chorea YES NO
- Mental retardation YES NO
- If YES, was the person tested for Fragile X? YES NO
- Other inherited genetic or chromosomal disorder? YES NO
- Maternal metabolic disorder (diabetes, PKU) YES NO

Have YOU or the FATHER of your baby had a CHILD with a BIRTH DEFECT not listed above? YES NO

Do YOU or the FATHER of your baby have a BIRTH DEFECT? YES NO

Do you a history of RECURRENT PREGNANCY LOSS or a STILLBIRTH? YES NO

Have you taken any MEDICATIONS since your last menstrual period other than prenatal vitamins (including vitamins, supplements, over-the-counter-meds, drugs, and alcohol)? YES NO

Have you had any other GENETIC or ENVIRONMENTAL EXPOSURES to discuss? YES NO

INFECTION HISTORY:

Do you live with someone with TB or who has had recent TB EXPOSURE? YES NO

Do you or your partner have GENITAL HERPES? YES NO

Have you had a RASH or VIRAL ILLNESS since your last menstrual period? YES NO

Have you had CHICKEN POX in the past? YES NO

 If NO, have you had the CHICKEN POX VACCINE? YES NO

Do you have any CATS at home? YES NO

Do you have any CLOSE CONTACT WITH CHILDREN other than your own on a regular basis? YES NO

I have filled out this form completely and to the best of my ability.

Signature _____ Date ____/____/____