New Patient OB Form

Name ____ Age ________ DOB _____ /_____ /______ Date _____ /_____ /______

PAST MEDICAL HISTORY:

Please list your past and current MAJOR MEDICAL ILLNESSES: ☐ **NONE**

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

When was your last PAP SMEAR? _____ /_____ /______ was it normal? ☐ YES ☐ NO

Do you have any history of ABNORMAL PAP SMEARS? ☐ YES ☐ NO If YES, explain: ______________________________

Have you ever been diagnosed with any of the following SEXUALLY TRANSMITTED DISEASES? ☐ YES ☐ NO

☐ HERPES ☐ HIV / AIDS ☐ SYPHILIS ☐ CHLAMYDIA ☐ GONORRHEA

PAST SURGICAL HISTORY:

Please list all of your prior SURGERIES (include common surgeries such as c-sections and cosmetic surgery):

Surgery	Year	Surgery	Year
1. ______________________	_____/_____/_____	5. ______________________	_____/_____/_____
2. ______________________	_____/_____/_____	6. ______________________	_____/_____/_____
3. ______________________	_____/_____/_____	7. ______________________	_____/_____/_____
4. ______________________	_____/_____/_____	8. ______________________	_____/_____/_____

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis:

Medication	Dose	Medication	Dose
1. ______________________	___________	5. ______________________	___________
2. ______________________	___________	6. ______________________	___________
3. ______________________	___________	7. ______________________	___________
4. ______________________	___________	8. ______________________	___________

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

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

ALLERGIES:

Please list all ALLERGIES TO MEDICATIONS:

Medication	Reaction *(rash, shortness of breath, etc.)*
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________

Please list any severe FOOD or ENVIRONMENTAL ALLERGIES you have: ______________________________

Are you allergic to LATEX? ☐ YES ☐ NO

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EILEEN CASSIDY, MD ▪ LYNN DRIVER, MD ▪ SUSAN MACKEY, MD ▪ ERIN YU, MD ▪ MELISSA WALCO, MD

REPRODUCTIVE HISTORY:

How many TIMES have you been pregnant? ________________

How many LIVING CHILDREN do you have? ________________

Have you delivered any children PREMATURELY (before 37 weeks)? ☐ YES ☐ NO If YES, how many? ______________

Have you had any MISCARRIAGES? ☐ YES ☐ NO If YES, how many? ____________

Have you had any ELECTIVE ABORTIONS? ☐ YES ☐ NO If YES, how many? ____________

FAMILY HISTORY

Do you have a FAMILY HISTORY of any of the following problems?

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

1.	High blood pressure	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
2.	Diabetes	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
3.	Heart disease	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
4.	Breast cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
5.	Ovarian cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
6.	Colon cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
7.	Thyroid disorder	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
8.	Osteoporosis	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
9.	Blood clotting disorder	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
10.	Deep venous thrombosis *(DVT – blood clot deep in leg)*	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
11.	Autoimmune disorders *(such as lupus, rheumatoid arthritis, etc)*	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF

12. Other ____

MENSTRUAL HISTORY:

Describe your periods before your pregnancy:

- At what age did you START YOUR PERIODS? ____________
- 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 _____/_____/______