

# 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 ( <i>rash, shortness of breath, etc.</i> )
1. _____	_____
2. _____	_____
3. _____	_____

Please list any severe FOOD or ENVIRONMENTAL ALLERGIES you have: \_\_\_\_\_

Are you allergic to LATEX?  YES  NO



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

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