OBSTETRICAL HISTORY REVIEW

NAME:	DOB:	DATE:
_____	_____	_____

PREGNANCY HISTORY

Pregnancy # Baby's Name	Date	Doctor's Name	Weeks at Delivery	Weight/Sex	Normal/Cesarean- Complications
Other: _____ _____					

SINCE LAST MENSTRUAL PERIOD: _____ (Date of Last Period)
Any Exposure to: Fever, Medications, Radiation, Viral Illness, other substances? If yes, please specify:

_____
_____
_____

DEMOGRAPHIC INFORMATION (Patient)

Primary Language _____	Birthplace _____	Ethnicity _____
Marital Status _____	Occupation _____	Employer _____
Education Level _____	Religion _____	
Exercise Frequency/Type _____		
Father of Baby (or other significant family member):		
Name _____	Occupation _____	Ethnicity _____
Emergency Phone Number _____		

MEDICAL/SURGICAL HISTORY

No ( ) Yes ( ) Diabetes	No ( ) Yes ( ) Thyroid Dysfunction	No ( ) Yes ( ) Breast Problems
No ( ) Yes ( ) Hypertension (blood pressure)	No ( ) Yes ( ) History of Blood Transfusion	No ( ) Yes ( ) GYN Surgery
No ( ) Yes ( ) Heart Disease	No ( ) Yes ( ) Tobacco	No ( ) Yes ( ) Operations/Hospitalization
No ( ) Yes ( ) Auto Immune Disorder	No ( ) Yes ( ) Alcohol	No ( ) Yes ( ) Anesthetic Complications
No ( ) Yes ( ) Kidney Disease	No ( ) Yes ( ) Drugs	No ( ) Yes ( ) Abnormal Pap Smear
No ( ) Yes ( ) Neurologic/Epilepsy	No ( ) Yes ( ) Rh sensitized	No ( ) Yes ( ) Uterine Anomaly/ DES
No ( ) Yes ( ) Psychiatric	No ( ) Yes ( ) Pulmonary (Asthma, etc)	No ( ) Yes ( ) Infertility
No ( ) Yes ( ) Depression/ postpartum	No ( ) Yes ( ) Seasonal Allergies	No ( ) Yes ( ) IVF
No ( ) Yes ( ) Hepatitis/ Liver Disease	No ( ) Yes ( ) Latex/Drug Allergies	No ( ) Yes ( ) Relevant Family History
No ( ) Yes ( ) Varicosities/Phlebitis	No ( ) Yes ( ) Trauma/Violence	_____

INFECTION HISTORY

No ( ) Yes ( ) History of TB/Exposure	No ( ) Yes ( ) Hepatitis B, C	No ( ) Yes ( ) Chlamydia
No ( ) Yes ( ) Patient or Partner with Herpes	No ( ) Yes ( ) STD/STI	No ( ) Yes ( ) Syphilis
No ( ) Yes ( ) Rash/Viral illness since pregnant	No ( ) Yes ( ) HPV	
No ( ) Yes ( ) HIV	No ( ) Yes ( ) Gonorrhea	

MEDICAL CONDITIONS	SURGERIES	YEAR

ALLERGIES

GENERAL

No ( ) Yes ( ) Agree to Blood Transfusion (in case of emergency)	No ( ) Yes ( ) Wears seat belt
No ( ) Yes ( ) Desires Tubal ligation/Sterilization	No ( ) Yes ( ) Plans to take Prenatal Classes
No ( ) Yes ( ) Enrolled in the WIC Prenatal Care Program	Planned Baby Feeding ( ) Breast ( ) Bottle ( ) Both

GENETIC SCREENING/RISK FACTORS (include patient, baby's father or anyone in the family)

No Yes		Mother	Father	Relative
No ( )	Yes ( ) Patient will be 35 years or older at the time of delivery			
No ( )	Yes ( ) Thalassemia			
No ( )	Yes ( ) Neural Tube Defect (spina bifida, spinal defect)			
No ( )	Yes ( ) Congenital Heart Defect			
No ( )	Yes ( ) Down Syndrome (or other chromosomal defect)			
No ( )	Yes ( ) Tay-Sachs, Canavan, Gancher (Ashkenazi Jewish)			
No ( )	Yes ( ) Familial Dysantonomia			
No ( )	Yes ( ) Sickle Cell Disease or Trait			
No ( )	Yes ( ) Hemophilia or other Blood Disorder			
No ( )	Yes ( ) Muscular Dystrophy			
No ( )	Yes ( ) Cystic Fibrosis			
No ( )	Yes ( ) Huntington's Chorea			
No ( )	Yes ( ) Mental Retardation/ Autism			
No ( )	Yes ( ) Other inherited Chromosomal/Genetic Disorder			
No ( )	Yes ( ) Maternal Diabetes/ Thyroid Disorder			
No ( )	Yes ( ) Other Birth Defects			
No ( )	Yes ( ) Recurrent pregnancy loss or stillbirth			

No ( ) Yes ( ) Medications (including vitamins, other the counter medications, illicit drugs, alcohol, etc. since last period)

_____

OB HIGH RISK FACTORS (Patient)

No ( ) Yes ( ) Age under 20 or over 35
No ( ) Yes ( ) Less than 8th grade education
No ( ) Yes ( ) Small Pelvis
No ( ) Yes ( ) Small stature (< 5 feet)

ADDICTION

No ( ) Yes ( ) Alcohol
No ( ) Yes ( ) Drug use
No ( ) Yes ( ) Smoking

SOCIAL FACTORS

No ( ) Yes ( ) Abusive Relationship
No ( ) Yes ( ) Exposure to Cats
No ( ) Yes ( ) Lacks Family Support
No ( ) Yes ( ) Poor Living Environment
No ( ) Yes ( ) Significant Social issues

GYNECOLOGIC HISTORY

No ( ) Yes ( ) Cervical lacerations/Cone
No ( ) Yes ( ) Incompetent Cervix
No ( ) Yes ( ) Infertility
No ( ) Yes ( ) Past Uterine Surgery
No ( ) Yes ( ) Previous Abnormal Pap
No ( ) Yes ( ) Uterine Anomalies
No ( ) Yes ( ) Multiple Prior Deliveries (> 4)

PAST PREGNANCY

No ( ) Yes ( ) 2 or more abortions
No ( ) Yes ( ) 5 or more prior deliveries
No ( ) Yes ( ) Abnormal labor
No ( ) Yes ( ) ABO Incompatibility
No ( ) Yes ( ) Anesthetic Intolerance
No ( ) Yes ( ) Cervical Incompetence
No ( ) Yes ( ) Chorioamnionitis
No ( ) Yes ( ) Congenital Anomalies
No ( ) Yes ( ) Cesarean Section
No ( ) Yes ( ) Fetal/Neonatal Death
No ( ) Yes ( ) Gestational Diabetes
No ( ) Yes ( ) Group B Strep Positive
No ( ) Yes ( ) Hemorrhage during pregnancy
No ( ) Yes ( ) Infant > 4000gm or 9 lbs
No ( ) Yes ( ) Intrauterine Growth Restriction
No ( ) Yes ( ) Late Delivery
No ( ) Yes ( ) Low Birth Weight infant
No ( ) Yes ( ) Neurologically injured baby
No ( ) Yes ( ) Oligohydramnios
No ( ) Yes ( ) Placenta Previa
No ( ) Yes ( ) Polyhydramnios
No ( ) Yes ( ) Pre-eclampsia/Eclampsia
No ( ) Yes ( ) Premature Rupture Membranes
No ( ) Yes ( ) Rh Isoimmunization

THIS PREGNANCY

No ( ) Yes ( ) 2nd pregnancy in 12 months
No ( ) Yes ( ) Bleeding
No ( ) Yes ( ) Abnormal labor
No ( ) Yes ( ) Oligohydramnios
No ( ) Yes ( ) Polyhydramnios
No ( ) Yes ( ) Placental Abruption
No ( ) Yes ( ) Poor Compliance
No ( ) Yes ( ) Premie Rupture Membranes
No ( ) Yes ( ) Pregnancy Hypertension
No ( ) Yes ( ) Threatened Premature Labor
No ( ) Yes ( ) Uncertain Dates
No ( ) Yes ( ) Excessive weight gain
No ( ) Yes ( ) Poor weight gain

MEDICAL HISTORY

No ( ) Yes ( ) Anemia
No ( ) Yes ( ) Anticoagulant use
No ( ) Yes ( ) Heart Disease, mild
No ( ) Yes ( ) Heart Disease, mod/severe
No ( ) Yes ( ) Chronic Renal Disease
No ( ) Yes ( ) Diabetes Mellitus
No ( ) Yes ( ) Epilepsy/ Seizures
No ( ) Yes ( ) Hepatitis
No ( ) Yes ( ) Herpes Simplex
No ( ) Yes ( ) HIV
No ( ) Yes ( ) Hypertension
No ( ) Yes ( ) Lung Disease
No ( ) Yes ( ) Phenylketonuria
No ( ) Yes ( ) Thromboembolism
No ( ) Yes ( ) Thyroid Dysfunction