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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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 _____/_____/_____

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