NEW OB PATIENT INFORMATION

Provider: ___________________________ *Date:* ___________

Patient Name: ____ DOB: ___________
Race/Ethnicity: ___________________________ Marital Status: _________________
Occupation: _______________________________ Employer: ______________________________

Partner Information
Name: ____ Age: ___________
Race/Ethnicity: ___________________________ Phone Number: ____________________
Occupation: _______________________________ Employer: ______________________________

Obstetric History: Please list ALL prior pregnancies, including miscarriages and terminations.

Date of Delivery	*Gestational Age at Delivery*	*Length of Labor*	*Weight of Baby*	*Type of Delivery (vaginal/ c-section)*	*Anesthesia (Y/N)*	*Preterm Labor (Y/N)*	*Sex of Baby (M/F)*	*Place of Delivery*

*In **PREVOUS** pregnancies have you experienced:*

- ☐ Active tuberculosis
- ☐ Amniotic fluid problem
- ☐ Blood clot
- ☐ Chromosomal anomalies/problems
- ☐ Fetal growth restriction
- ☐ Fetal or neonatal death
- ☐ Gestational diabetes
- ☐ Hemorrhage
- ☐ Incompetent cervix
- ☐ Neurological damaged infant
- ☐ Preeclampsia or High Blood Pressure

*In your **CURRENT** pregnancy have you experienced:*

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Fever
- ☐ Headache
- ☐ Nausea
- ☐ Rashes or viral illness since your last period
- ☐ Urinary complaints
- ☐ Vaginal bleeding
- ☐ Vaginal discharge/odor
- ☐ Vomiting
- ☐ Other: ________________________

Current Pregnancy:
List the current medications and vitamins you are taking: ____
Is this pregnancy your second pregnancy in 12 months? **Y / N**
Was any assistive technology used to achieve your current pregnancy? **Y / N** If so, what type? ______________
Who is your fertility provider? ____

What products have you been exposed to since your last menstrual period?

- ☐ Caffeine
- ☐ Cats
- ☐ Over-the-counter medication
- ☐ Prescription medication
- ☐ Alcohol
- ☐ Chemical or radiation exposure
- ☐ Tobacco products
- ☐ IV drug use by you or your partner
- ☐ Illicit drugs
- ☐ Other: _________________________

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YOUR Medical History:

☐ Abnormal pap smear	☐ Breast problems	☐ Heart disease	☐ Mitral valve prolapse	☐ Tuberculosis
☐ Anxiety/Depression	☐ Breast surgery	☐ Hepatitis	☐ Reactions to anesthesia	☐ Uterine anomaly
☐ Asthma	☐ Diabetes	☐ Hospitalizations	☐ Rheumatic fever	☐ Uterine surgery
☐ Autoimmune disorder	☐ DES exposure	☐ Hypertension	☐ Seasonal allergies	☐ Varicosities/Phlebitis
☐ Blood transfusion	☐ Epilepsy	☐ Kidney Disease	☐ Sexually transmitted infections	☐ Other: ____________________ ____________________
☐ Bowel disease	☐ Genital herpes	☐ Liver Disease	☐ Thyroid dysfunction	____________________ ____________________

Do you know your blood type? **Y / N** Are you Rh negative? **Y / N**
Do you have any diet restrictions or follow any special diets? ____________________
Do you exercise? How often? What type? ____________________
How often did you get a period prior to pregnancy? ____________________
When was the **FIRST** day of your last period? ____________________
When was your last pap smear? Was it normal? ____________________

FAMILY Medical History: Please check all that apply to the PATIENT'S family and note WHO has the specified disorder

☐ Major pregnancy complications ____________________
☐ High blood pressure ____________________
☐ Diabetes ____________________
☐ Cancer ____________________
☐ Preeclampsia ____________________
☐ Thyroid disease ____________________
☐ Other diseases or disorders relevant to your pregnancy ____________________

Genetic History:

Have you or the father of your child had a child born with birth defects or have birth defects yourself? **Y / N**
Have you ever had genetic counseling and/or chromosomal studies? **Y / N**

*Have babies in **YOU** or your **PARTNER'S** family with any of the following:*

☐ Down syndrome ____________________
☐ Deformities ____________________
☐ Mental retardation____________________
☐ Hemophilia ____________________
☐ Emotional problems ____________________
☐ Muscular dystrophy ____________________
☐ Birth defects ____________________
☐ Cystic fibrosis ____________________
☐ Neural tube defects ____________________
☐ Other: ____________________

*Some genetic problems may occur more frequently in couples with certain racial or ancestral background. Please **CIRCLE** all that apply to **YOU** or the **BABY'S FATHER:***

Jewish Ancestry / Black / Italian / Greek / Mediterranean / Philippino / Southeast Asian

Home Safety

Do you wear seatbelts? **Y / N**
Do you have working smoke detectors and carbon monoxide detectors in your home? **Y / N**
Do you have firearms in your home? **Y / N**

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