OB Patient History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Pharmacy: _____

First day of last period: _____	Pre-Pregnancy Weight: _____	Regular periods: ☐ Yes ☐ No
On Birth Control when conceived: ☐ Yes ☐ No	Months attempting pregnancy: _____	
Father: Weight: _____ Height: _____ Age: _____ Name: _____ Phone: _____		

OB History

History of Infertility:
☐ Yes ☐ No

Number of Pregnancies: ____

Number of Abortions: ____

Number of Miscarriages: ____

Number of full term births: ____

Number of Preterm births: ____

How many live children: ____

Please list all pregnancies:

Date of delivery	How many weeks	Vaginal, C-Section, VBAC	Baby's weight	Male or Female	Preterm Labor		Comments
					Yes	No	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	
					☐	☐	

GYN Procedures:

☐ Colposcopy Date: _____ ☐ Cryotherapy Date: _____ ☐ Cone Biopsy Date: _____ ☐ LEEP Date: _____

Infection History & Genetic Screening: (Mark all that apply)

☐ Patient age 35 years or older

Infection History:

☐ Lives with someone with TB or are exposed to TB
☐ Patient or Partner with history of genital herpes
☐ Rash or viral illness since last menstrual period
☐ Hepatitis B or C
☐ History of STDs: gonorrhea, chlamydia, HPV, HIV, syphilis
☐ Other: _____

Genetic Screening:

☐ Sickle cell disease or trait (African)
☐ Thalassemia (Italian, Greek, Mediterranean, or Asian background) MCV <80?
☐ Hemophilia or other blood disorder
☐ Canavan disease (Ashkenazi Jewish)
☐ Familial dysautonomia (Ashkenazi Jewish)
☐ Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)
☐ Cystic Fibrosis
☐ Congenital heart defect
☐ Neural tube defect (meningomyelocele, spina bifida, or anencephaly)
☐ Spinal muscular dystrophy
☐ Muscular dystrophy
☐ Down syndrome
☐ Intellectual disability
☐ Autism: [☐ If yes, this person tested for Fragile X]
☐ Other inherited genetic and chromosomal disorder
☐ Huntington's Chorea
☐ Patient or baby's father had a child with birth defects not listed
☐ Other: _____

Completed by:

Patient/Representative Signature: _____ Date: _____ Time: _____

Relation to patient: _____

central peninsula women's health

Patient Label