OB Work up

Prenatal Form

Name:_____ DOB:_____ Age: _____

Home phone number: _____ Cell number: _____ Work number: _____

Education (last grade completed):_____ Occupation: _____

Support person name: _____ Relationship: _____ Phone: _____

Allergies (and your reactions to them):

OB History:

Pre-pregnancy weight:_____ FIRST DAY OF LAST PERIOD:_____

# of Pregnancies	Total #	Full Term	Premature	Abortion	Miscarriage	Tubal	Living

Family history: Please indicate any of the following pertaining to you, your partner, close family, or child.

History of:	Yes	No
Italian, Greek, Asian, or Mediterranean		
Open spine, abnormal brain		
Heart defect at birth		
Down Syndrome		
Jewish		
Sickle cell disease or trait		
Hemophilia		
Muscular Dystrophy		
Cystic fibrosis		
Huntington Chorea		
Mental retardation/Autism		
PKU		
Birth defects not listed above		
Three or more miscarriages		
Stillbirth		
Thalassemia		
Tay-Sachs		
Maternal Metabolic Disorder		

Additional family history: Please indicate any conditions you have a history of, as well as if any of your family members have histories.

Condition	You *yes/no*	Family history? *Yes/no (if yes, please list who)*
Varicosities/phlebitis		
Postpartum depression		
D(Rh) factor		
Drug/Latex allergies		
Anesthetic complications		
Malignancies		
Rheumatic fever		
Chicken pox or vaccine		

PATIENT *INFECTION* HISTORY	Yes	No
Exposure to TB		
Herpes in you or your partner		
Rash or virus since pregnant		
Previous Group B strep-infected child		
History of STD (HPV, GC, Herpes, Chlamydia, Syphilis)		
History of HIV		
Hepatitis		
Other		

Do you have a cat? *yes__ no__*

When was your last tDAP vaccine? _____

When was your last flu vaccine? _____

Other information you believe is important to know: ___

_____

_____

Paternal Information *Choose not to disclose (initial here)* ____

Name: _____

Date of Birth: _____

Phone number: _____

Occupation: _____

Race/ethnicity: _____

Prenatal vitamins: Yes No

Please list all medications and supplements you are currently taking:				
Medication	Dates Taken	Dose/Strength	Time per day	Purpose

Prenatal Form

Circle any of the following conditions you are currently experiencing:

NEUROLOGICAL
Headaches
Memory problems
Numbness/tingling
Seizures
Blurred vision

RESPIRATORY
Shortness of breath
Chronic cough
Coughing up blood
Difficulty/pain breathing

GASTROINTESTINAL
Bloody stool
Nausea/vomiting
Diarrhea
Constipation

CONSTITUTIONAL
Weight loss
Weight gain
Fever
Fatigue

URINARY
Urination frequency
Pain with urination
Leaking of urine
Bloody urine

ENT
Hearing loss
Hearing problems
Congestion
Sore throat

SKIN
Itching
Burning
Rash

PSYCH
Depression
Crying spells

MUSCULOSKELETAL
Muscle/joint pain
Swelling of joints
Bone loss

HEMO/LYMPH
Bruising/bleeding
Anemia
Swollen lymph nodes

CARDIOVASCULAR
Chest pain
Irregular heart beat
Swollen legs

EYES
Vision changes
Double vision
Glasses

REPRODUCTIVE
Irregular menses
Menopause
Sexual dysfunction

ENDO
Cold intolerance
Thyroid problems

Social History:

SMOKING	Used to	Currently
# of packs per day		
# of years smoking:		
Did you quit? When?		
DRINKING		
# of occasions/week		
# of drinks in one day		
MOST # of drinks in one day		
Did you quit? When?		
USE OF RECREATIONAL DRUGS		
Do you / have you ever used drugs recreationally? *yes___ no___ If yes, list which + frequency:*		

Patient OB/Pregnancy History

COVID VACCINE:
YES: NO:

Total # of pregnancies_____ Total # of living children: _____

Deliveries:

Date	Weeks at delivery	Labor time (hrs)	Birth weight	Sex of baby	Route of delivery	Anesthesia: natural, IV, epidural, etc	Hospital	Child OK (x if no)	Premature labor (x if yes)

Hospital + Surgical History:

Have you ever received a blood transfusion? *yes*___ *no*___
Have you ever been hospitalized overnight? If so, for what?

Have you ever had surgery? List all surgeries and biopsies, along with their dates:

Office use only- Ht:_____ Wt:_____ BP:_____ Temp:_____