Desert West Obstetrics and Gynecology
Confidential Obstetrical History

Name ___________________________ Birth date __________ Age _____ Date ___________

Gynecologic Health History

LMP (first day of your last period): ___________

___ Definite
___ Unknown date
___ Approximate date

Were your periods regular before pregnancy? No____ Yes____

How often did your cycles occur? _________________________________-(# of days from start of one cycle to start of next cycle)

Were you on Birth Control at time of conception? No___ Yes___
If yes, what type of Birth Control were you using? __________________________

What age were you when you started your first period? _________________________

Have you had a positive pregnancy test? No___ Yes___
If yes, when and where was the test done? _________________________________

Was this a planned pregnancy? No ____ Yes ____

Was this pregnancy a result of In vitro fertilization? No____ Yes____

If yes, donor sperm? No ____ Yes ____

If yes, donor egg? No ____ Yes ____

If yes, what was date of conception? _________________________

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Total number of pregnancies

Full Term	Premature	Cesarean Section	Vaginal Delivery	Living	Multiple births	Abortion	Miscarriage	Ectopic

Have you had a positive Group B Strep status with any pregnancies? No _____ Yes____ Unsure____

Pregnancy Details

Preg #	Sex	Month/ Year of delivery	Number of weeks	Babies Weight	Hrs of Labor	Delivery Type	OB/Neonatal Problems	Delivery Doctor

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Current Medications (Prescription, over the counter, herbal)	Prescribing Doctor	Dose	Instructions	Reason Used

Medical History

Have you had or have any of the following conditions:

Disease/Condition	Yes	No	Onset date	Treatment
1. Diabetes				
2. Hypertension				
3. Heart Disease				
4. Autoimmune Disorder				
5. Kidney Disease/UTI				
6. Neurologic/Epilepsy				
7. Psychiatric				
8. Depression/Postpartum Depression				
9. Hepatitis/liver disease				
10. Varicosities/phlebitis/ blood clot				
11. Thyroid Dysfunction				
12. Trauma/Violence				
13. History of blood Transfusions				
14. RH Negative				
15. Pulmonary (TB/Asthma)				
16. Seasonal Allergies				
17. Breast problems				
18. Anesthetic complications				
19. Uterine anomaly/ DES exposure				
20. Infertility				
21. History of abnormal pap smear				
22. Received HPV vaccine				

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Infection History

	Yes	No	Onset Date	Treatment
1. Exposed to/live with someone with TB				
2. Patient/Partner with History genital Herpes				
3. Rash/viral Illness since Last period				
4. Have you had Chicken pox				
5. Hepatitis B				
6. Hepatitis C				
7. **History of:**				
STD				
Gonorrhea				
Chlamydia				
HPV/Warts				
HIV				
Syphilis				
8. Other				

Medical / Surgical History ***(Include injuries and conditions requiring medications i.e.-high blood pressure, diabetes, seizures, etc)***

Condition/Disease	Date	Treatment

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Allergies to medications/food/environment	Reaction

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Circle Yes/No	Family Member	Family Members 1st Name	Age of Onset	Age of Death	Cause of Death (Circle)
Cancer of Breast	Yes No					Yes No
Cancer of Ovary	Yes No					Yes No
Cancer of Uterus	Yes No					Yes No
Cancer of Cervix	Yes No					Yes No
Cancer of Colon	Yes No					Yes No
Diabetes	Yes No					Yes No
Tuberculosis (TB)	Yes No					Yes No
Heart Disease	Yes No					Yes No
High Blood Pressure	Yes No					Yes No
Blood clot/PE	Yes No					Yes No
Other:						Yes No
						Yes No
						Yes No
						Yes No

Symptoms since your last period?

____

____

What medications have you taken since your last period?

____

____

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Genetic History
(Includes patient, baby's father, or anyone in either family)

	Yes	No	Mother(patient)	Father(baby's)	Other relative and relationship
1. Patient's age 35 or older at delivery					
2. Thalassemia					
3. Neural tube defect					
4. Congenital heart defect					
5. Down syndrome					
6. Tay-sachs					
7. Canavan disease					
8. Familial dysautonomia					
9. Sickle cell disease or trait					
10. Hemophilia or other Blood disorders					
11. Muscular dystrophy					
12. Cystic fibrosis					
13. Huntington's chorea					
14. Mental retardation/ Autism					
15. Other inherited genetic or chromosomal disorder					
16. Metabolic Disorder (e.g. PKU, Type 1 Diabetes)					
17. Patient or baby's father had a child with birth defects not listed above					
18. Recurrent pregnancy loss or stillbirth					
19. Other					

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Social History

Primary LanguageSpoken_______________________________Race________________________

Education_________________________ Degree Obtained___________________________

Baby's father ___________________ Baby's father race ______________________

Support person for pregnancy _____________________________

Pediatrician _______________________

Will you be breast feeding? No ____ Yes___
Will you be bottle feeding? No ____ Yes ___
Will you be breast and bottle feeding? No ___ Yes ___

If medically necessary, would you agree to a transfusion? No_____ Yes_____

Do you desire sterilization after pregnancy? No ___ Yes ___

Do you smoke? No_____ Yes_____ If yes, type of tobacco?________ Pks/day_____ Number of years_____
If yes, amount during pregnancy? _________________________________
Second hand smoke exposure? No _____ Yes _____

Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol ______________________________
How often? ______________________ Amount _____________Last drink_____________________
If yes, amount during pregnancy? __________________________________

Do you consume caffeine? No_____ Yes_____ If yes, amount daily? ______________ Type ________________

Do you use recreational drugs? No_____ Yes____ If yes, what type? ____________________ Amount __________
If yes, amount during pregnancy? ____________________

(We do recommend that you discontinue use of nicotine, alcohol, caffeine, and recreational drugs)

Do you have a regular exercise program? No_____ Yes_____ Hours/week________________________

Are there animals in the home? No_____ Yes_____ If yes, what kind? ___________________________

Is the patient the individual who cleans up after the animals? No_____ Yes_____

Do you have smoke detectors in your home? No____ Yes____

How many sexual partners do you have? None_____ One_____ 2-5_____ 5+_____

Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____
If yes, please explain ____

____