SHARP Rees-Stealy Medical Group
Department of Obstetrics and Gynecology

OBSTETRICAL HISTORY

Personal Information

Name: ____
Ethnicity: ____
Marital Status: (please circle) Single Married Widowed Divorced Separated
Name of baby's father: _________________________ Daytime phone: ________________________
Occupation: (please circle) Homemaker Student Outside Work
Type of work ______________________
Education Level: (last grade completed) ___________
Insurance Carrier: ____
Emergency Contact - Name: ___________________________Telephone: ______________________
Do you have any religious or cultural beliefs that we should be aware of? ______________________
____
If deemed necessary during delivery, would you medically accept a blood transfusion?
Yes__________ No__________
Were you taking any form of oral birth control/IUD at time of conception? ____________________
When was your most recent pap smear?___________
Any history of abnormal pap smears or HPV? No _________ Yes________ If so, when? ________

Menstrual History

First day of last menstrual period? _____________
How old were you when your periods started? _____________
Are your periods monthly? _____________
How many days in your cycles? _____________
Was it normal? _____________

Past Pregnancies

Date of delivery	Hours in labor	Birth weight	Type of delivery	Place of delivery	Complications	Anesthesia Used?	Male/Female
1.							
2.							
3.							

Have you had a history of premature labor? _____________
Have you had any miscarriages? ______How many? ________ When? ____________
Have you had an ectopic pregnancy? _____________
Have you ever had any abortions? ______How many? ________When? ____________

Past Medical History

Height: ____________ Pre-Pregnancy Weight: ____________
Do you have allergies to medications? ____
Do you have allergies to Latex? ____

Please circle problem and explain positive remarks.

1. Neurologic/Epilepsy
2. Thyroid Dysfunction
3. Breast Disease
4. Pulmonary (TB/Asthma)
5. Heart Disease
6. Hypertension
7. Cancer
8. Hematologic Disorders
9. Anemia
10. Gastrointestinal Disorders
11. Liver Disease
12. Kidney Disease/UTI
13. Varicosities/Phlebitis
14. Diabetes (Type1, Type 2 or Gestational)
15. Autoimmune Disorders
16. Dermatological Disorders
17. GYN Surgery
18. History of Blood Transfusions
19. Infertility
20. Assisted Reproductive Technology
21. Uterine Anomaly/DES
22. History of Abnormal Pap
23. Psychiatric Illness
24. Depression/Post partum Depression
25. Trauma/Violence
26. Family History:
    Diabetes
    Hypertension
    Breast/Ovarian Cancer
    Preterm Labor
27. Surgeries/hospitalizations Type of surgery and dates____
28. Anesthesia complications What type? ____

Do you smoke?	_______	How long?	_______	Amt./Day	_______
Alcohol?	_______	How long?	_______	Amt./Day	_______
Street Drugs?	_______	How long?	_______	Amt./Day	_______

List medications, alcohol and street drugs used since last menstrual period? ______________________________
____

Genetic Screening/Teratology Information

Please circle if there is a history of: (This includes patient, baby's father or anyone in either family.)

1. Thalassemia (Italian, Greek, Mediterranean or Asian Background)
2. Neural Tube Defects (Meningomyelocele, Spina Bifida or Anencephaly)
3. Congenital Heart Defects
4. Down Syndrome
5. Tay-Sachs (Jewish, Cajun, French Canadian)
6. Sickle Cell Disease or Trait (African)
7. Hemophilia
8. Muscular Dystrophy
9. Cystic Fibrosis
10. Huntington Chorea
11. Mental Retardation/Autism
12. Other inherited Genetic or Chromosomal Disorders
13. Do you have a metabolic disorder (Insulin Dependent Diabetes, PKU)
14. Patient or baby's father had a child with a birth defect not listed above.
15. List medications, alcohol and street drugs used since last menstrual period.

Infection History

1. Live with someone with TB or exposed to TB? _________
2. Patient or partner with Genital Herpes _________
3. Rash or viral illness since last period? _________
5. History of STI's (Gonorrhea, Chlamydia, HPV, Syphilis, PID, HIV) _________
6. History of Hepatitis B or Hepatitis C? _________
7. Have you had chicken pox? Child________ Adult_______ Immunized? _______