Western OB/GYN
A division of Ridgeview Clinics

Prenatal Medical History Form

Today's date _____
Name _____ Date of birth _____
Father of baby/partner _____ Involved in pregnancy: Y N
What was the first day of your last menstrual period: _____ Was it normal: Yes No
Age your periods began: _____ Usual length of your menstrual cycle: _____
Usual # of days your periods last: _____ Date of last pap smear: _____ Normal: Y N
Date of 1st positive pregnancy test: _____
Current medications: _____
Allergies: _____ Date of Tdap immunization(Tetanus with Pertussis)_____

Previous Pregnancy History

Total # preg (including this one) _____ Full term _____Premature (<37 wk) _____ Termination_____
Miscarriage _____ Ectopic (tubal preg) _____ Multiple births _____ Living children _____
Details of your last 8 pregnancies:

Delivery date	Gest. Age	Hours labor	Birth weight	Sex	Type Delivery	Anesth	Early Labor	Complications Comments	Loc	Doctor Midwife

Since your last LMP have you used any: Alcohol _____ Tobacco _____ Street drugs ____
In the past 6 weeks, how much weight have you gained: _____#
Are there any issues with domestic violence: N Y If yes, explain: _____
Is there any pertinent family (mother, sister) pregnancy history: _____

Genetic screening: Circle Y (Yes) or N (no) Explain any yes answer

1. Patients age:
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background? Y N
3. Tay-Sachs (Ashkenazi, Jewish, French Canadian background)? Y N

4. Sickle cell disease or trait (African)? Y N
5. Down syndrome or other chromosomal problem? Y N
6. Hemophilia or other blood disorders? Y N
7. Muscular Dystrophy? Y N
8. Cystic fibrosis? Y N
9. Huntington's Chorea? Y N
10. Mental retardation/autism? Y N
11. Maternal metabolic disorder (Diabetes, PKU, etc)? Y N
12. Other inherited genetic or chromosomal disorder? Y N
13. Child with a birth defect not listed above? Y N
14. Patient or father of baby with a birth defect themselves? Y N
15. 3 or more first trimester (up to 12 weeks) miscarriages or still births? Y N

Infection history: Explain any yes answer.

Lives with someone with TB or TB exposed? Y N

Have had chicken pox in the past? Y N

Rash or viral illness since positive pregnancy test? Y N

History of STD (Gonorrhea, Chlamydia, Herpes, Syphilis, HIV)? Y N

Do you have a cat in your home? Y N

Do you have close contacts with children (risk for Parvovirus/Fifth's disease)? Y N

Please list any significant past medical history:

Please list any past surgical history:

Are you <u>currently</u> having <u>significant</u> problems with: (Please "x" all that apply):

☐ Body aches ☐ Night sweats	☐ Impaired vision	☐ Headaches ☐ Sinus congestion
☐ Breast lumps ☐ Tenderness ☐ Swelling ☐ Nipple discharge	☐ Chest pain ☐ Fainting	☐ Shortness of breath ☐ Wheezing ☐ Cough
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in stools	☐ Urinary urgency ☐ Frequency ☐ Pain ☐ Incontinence	☐ Skin rash ☐ Changes in moles or lesions
☐ Muscular weakness ☐ Incoordination ☐ Tingling/weakness	☐ Joint pain ☐ Muscle pain	☐ Excessive urination/thirst ☐ Cold or Heat intolerance
☐ Anxiety ☐ Depression ☐ Feeling confused ☐ Difficulty sleeping ☐ Excessive anger	☐ Easy bleeding/bruising ☐ Lymph node enlargement/tenderness	☐ Sinus allergy symptoms ☐ Frequent illnesses