OBSTETRICS – O'Connor Medical Clinic

1st day of Last Period: _____

Pregnancy Test (date): _____

Ultrasound (date): _____

Are your periods regular? Yes or No

Father of baby: _____

Primary Care (Family) Doctor:

Name:_____ Clinic: _____

Medications: _____

Are you taking prenatal vitamins? Yes or No

What are you allergic to? _____

Pharmacy: _____

Pregnancy History:

(How many?)

Pregnancies: _____

Deliveries: _____

Miscarriages: _____

Abortions: _____

Date	**Type of Delivery** (Vaginal or Cesarean Section)	**Term** or **Preterm**	**Baby weight**	**Complications?** (preeclampsia, diabetes, shoulder dystocia, hemorrhage)

Do you have any medical problems?

(circle all that apply)

Diabetes High Blood Pressure

Heart Disease Liver Disease

Kidney Disease Thyroid Disease

Asthma History of TB or +PPD

Depression/Anxiety DVT or PE Cancer

Other: _____

What surgeries have you had?

1)

2)

Does anyone in your family have birth defects? Yes or No

GYN History:

Have you had: an ABNORMAL pap test? Yes or No

a sexually transmitted infection? Yes or No

Did you get the HPV vaccine? Yes or No

Do you plan to breast-feed the baby? Yes or No

What birth control are you interested in? _____

Pills IUD Nexplanon Depo Condoms Tubal Ligation

Social History: Do you smoke? Yes or No

Do you drink alcohol? Yes or No

Do you have any pets? Yes or No

Occupation: _____

Would you accept blood transfusions? Yes or No