

**Please complete this NEW OB PATIENT INFORMATION form prior to your visit. Thank you**

DATE \_\_\_\_\_ NAME \_\_\_\_\_

Last First Middle Init

DOB \_\_\_\_\_ AGE \_\_\_\_\_ **LAST MENSTRUAL PERIOD** \_\_\_\_\_

EMAIL \_\_\_\_\_ PRIMARY CARE PHYSICIAN \_\_\_\_\_

PATIENT'S OCCUPATION \_\_\_\_\_

PARTNER'S NAME \_\_\_\_\_ PARTNER'S OCCUPATION \_\_\_\_\_

**PREGNANCY HISTORY ( ) No Past Pregnancies**

DATE	VAGINAL	C-SECTION	ANESTHESIA	WEIGHT OF BABY	LOCATION OF BIRTH	DELIVERING DOCTOR	COMPLICATIONS

**MISCARRIAGES, ECTOPIC PREGNANCIES OR TERMINATIONS**

DATE	MISCARRIAGE	TERMINATION	ECTOPIC	COMPLICATIONS

**SINCE YOUR LAST MENSTRUAL PERIOD (PLEASE CHECK ANY THAT APPLY)**

Abdominal cramps _____	Rubella exposure _____	Symptoms since LMP:
Breast tenderness _____	Urinary complaints _____	
Edema (swelling) _____	Vaginal discharge _____	
Fever _____	Vaginal bleeding _____	
Headaches _____	Viral exposure _____	
Nausea / vomiting _____		
Radiation exposure _____		

**ALLERGIES ( ) No Known Allergies**

... for MD review

MEDICATION ALLERGY	REACTION
LATEX ALLERGY NO ( ) YES ( )	REACTION

**PLEASE CONTINUE...TURN OVER**

(1)

**SOCIAL HISTORY ( ) MARRIED ( ) SINGLE ( ) WIDOW ( ) DIVORCED**

- Are you currently sexually active? No ( ) Yes ( ) With a: Man ( ) Woman ( ) Both ( )
- How many sexual partners do you currently have? \_\_\_\_\_ during your lifetime? \_\_\_\_\_

**MEDICAL HISTORY: Do you currently have or have you been diagnosed with:**

DIABETES	No ( ) Yes ( )	TRAUMA / VIOLENCE	No ( ) Yes ( )
HYPERTENSION	No ( ) Yes ( )	BLOOD TRANSFUSIONS	No ( ) Yes ( )
HEART DISEASE	No ( ) Yes ( )	D (RH) SENSITIZED	No ( ) Yes ( )
AUTOIMMUNE DISORDER	No ( ) Yes ( )	LUNG DISEASE (ASTHMA, PNEUMONIA)	No ( ) Yes ( )
KIDNEY OR URINARY TRACT	No ( ) Yes ( )	SEASONAL ALLERGIES	No ( ) Yes ( )
NEUROLOGICAL / EPILEPSY	No ( ) Yes ( )	BREAST	No ( ) Yes ( )
PSYCHIATRIC	No ( ) Yes ( )	GYN SURGERY	No ( ) Yes ( )
DEPRESSION (INCLUDING POSTPARTUM	No ( ) Yes ( )	ABNORMAL PAP	No ( ) Yes ( )
HEPATITIS / LIVER DISEASE	No ( ) Yes ( )	UTERINE ABNORMALITIES	No ( ) Yes ( )
VARICOSE VEINS / PHLEBITIS	No ( ) Yes ( )	OVARIAN CYST / MASS	No ( ) Yes ( )
THYROID DISEASE / DISORDER	No ( ) Yes ( )	INFERTILITY	No ( ) Yes ( )
GASTROINTESTINAL	No ( ) Yes ( )	CANCER	No ( ) Yes ( )
OTHER	No ( ) Yes ( )	Type:	
		Date:	
	<b>AMT / DAY PRE PREGNANT USE</b>	<b>AMT / DAY PREGNANT</b>	<b># YEARS USE</b>
TOBACCO			
ALCOHOL			
DRUGS;ILLICIT / RECREATIONAL			
CAFFEINE			

**INFECTION HISTORY**

LIVE WITH SOMEONE WITH <b>TB OR EXPOSED TO TB</b>	No ( ) Yes ( )
DO YOU OR YOUR PARTNER HAVE <b>HISTORY OF GENITAL HERPES</b>	No ( ) Yes ( )
HAVE YOU HAD ANY OF THE FOLLOWING <b>INFECTIONS</b>	No ( ) Yes ( )
<i>Check if yes:</i> HEPATITIS B /C ____ STI ____ HPV ____ GONORRHEA ____ HIV ____ CHLAMIDYA ____ SYPHILLIS ____	
<b>VIRAL ILLNESS OR RASH</b> SINCE YOUR LAST MENTRUAL PERIOD	No ( ) Yes ( )
HAVE YOU HAD ANY <b>XRAYs</b> SINCE YOUR LAST MENTRUAL PERIOD	No ( ) Yes ( )
DO YOU HAVE A <b>CAT</b> AS A HOUSEHOLD PET	No ( ) Yes ( )
HAVE YOU TAKEN ANY <b>MEDICATIONS</b>	No ( ) Yes ( )
<i>If yes, please list:</i> _____	

**PAST SURGICAL HISTORY ( ) No Surgical History**

SURGERY	DIAGNOSIS	YEAR	SURGEON	COMPLICATIONS

- **Have you ever experienced complications from Anesthesia** No ( ) Yes ( )  
explain: \_\_\_\_\_
- **In the event you would need a blood transfusion, would you accept a transfusion** No ( ) Yes ( )

NAME \_\_\_\_\_

**FAMILY HISTORY (please check the appropriate columns)**

	Mother	Father	Sister	Brother	Other	Age onset or death	Comments
ALIVE AND WELL							
DECEASED							
BLEEDING / CLOTTING DISORDER							
CORONARY ARTERY DISEASE /HEART ATTACK							
HYPERTENSION OR STROKE							
DIABETES							
OSTEOPOROSIS							
THYROID DISEASE							
BREAST CANCER							
UTERINE CANCER							
OVARIAN CANCER							
COLON CANCER							
OTHER							

**OB GENETIC / RISK SCREENING**

WILL YOU BE **35 OR OLDER** AT THE TIME OF YOUR DUE DATE      No ( ) Yes ( )

**HAVE YOU, FATHER OR BABY, OR ANY FAMILY MEMBERS HAD A PREGNANCY OR CHILD AFFECTED BY:**

Please check if it applies:	YOU	FATHER OF BABY	FAMILY MEMBER
<b>ITALIAN, GREEK, ASIAN OR MEDITERRANEAN DESCENT</b>			
<b>If yes</b> , have either been screened for <b>Thalassemia</b> Results of screening:			
<b>JEWISH, CAJUN, FRENCH CANADIAN DESCENT</b>			
<b>If yes</b> , have either been screened for <b>Tay-Sachs</b> Results of screening:			
<b>JEWISH DESCENT</b>			
<b>If yes</b> , have either been screened for <b>Canavan disease</b> Results of screening			
<b>If yes</b> , have either been screened for <b>Familial dysautonomia</b> Results of screening:			
<b>If yes</b> , have either been screened for <b>Cystic fibrosis</b> Results of screening:			
<b>AFRICAN DESCENT</b>			
<b>If yes</b> , have either been screened for <b>sickle cell trait</b> Results of screening:			

**PLEASE CONTINUE...TURN OVER**

**HAVE YOU, FATHER OR BABY, OR ANY FAMILY MEMBERS HAD A PREGNANCY OR CHILD AFFECTED BY:**

	YOU	FATHER OF BABY	FAMILY MEMBER
NEURAL TUBE DEFECTS (SPINA BIFIDA, MENINGOMYELOCELE, ANENECEPHALY)			
CONGENITAL HEART DEFECT			
DOWN SYNDROME			
HEMOPHILIA / BLOOD DISORDER			
MUSCULAR DYSTROPHY			
CYSTIC FIBROSIS			
HUNTINGTON'S CHOREA			
AUTISM OR MENTAL DISORDER			
OTHER INHERITED OR GENETIC DISORDER			
MATERNAL INHERITED DISORDER (TYPE 1 DIABETES, PKU..)			
OTHER BIRTH DEFECTS			
RECURRENT PREGNANCY LOSS OR STILLBIRTH			

**MEDICATIONS ( ) NO MEDICATIONS (be sure to include over the counter meds and supplements) ... for MD review**

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	START DATE	NAME OF PRESCRIBING PHYSICIAN

**PHARMACY**

NAME	LOCATION / ADDRESS	PHONE NUMBER

**Thank you for taking the time to share this valuable information concerning your health.**

**Drs. Berger-Weiss, Potts, Levenson, Artis, Groves and Allison Ladner, CNM, WHNP**

**REV 2.2019**

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