MARSHALL

NEW PREGNANCY HISTORY OB/GYN

Name_____ Date of birth_____ Today's date_____

PREGNANCY DATING

First day of last period: _____

Are your periods regular? YES NO

Date of first positive pregnancy test: _____

Was this pregnancy conceived with any infertility procedures? YES NO

Have you had any ultrasounds during this pregnancy? YES NO

If Yes, then where? _____

VITALS

Your prepregnancy weight: _____ Your height: _____

GYN HISTORY

Year of last pap test? _____

Where did you have your last pap test? _____

Have you ever had any abnormal pap tests? YES NO If yes, what year? _____

Where was the abnormal pap test done?

_____

Have you ever had any surgery or procedures on your cervix? YES NO

What procedure or surgery was done? _____ What year? _____

Have you ever been treated for any sexually transmitted diseases? YES NO

Check any previous infections and list year:

- ☐ Chlamydia Year: _____
- ☐ Gonorrhea Year: _____
- ☐ Herpes Year: _____
- ☐ Trichomonas Year: _____
- ☐ Syphilis Year: _____
- ☐ HIV Year: _____
- ☐ Hepatitis C Year: _____
- ☐ HPV Year: _____

Does any current sexual partner have Herpes? YES NO

PAST PREGNANCIES

Delivery date					
Number of weeks					
Length of labor					
Birth weight					
Male/Female					
Vaginal, C/S, termination, miscarriage					
Place of birth					
Name of baby					
List any complications					
Did you breastfeed? For how long?					

FAMILY HISTORY

Does anyone in your family have: (circle if yes and list which relatives)

Diabetes

Osteoporosis

Heart Disease

Stroke

High blood pressure

Addiction

Breast cancer

Colon cancer

Ovarian cancer

Other?

SURGERIES AND HOSPITALIZATIONS

Please list all surgeries and hospitalizations	Year

Please list all medications	Dose	Reason for taking

Preferred Pharmacy _____

Do you have any allergies? YES NO
If yes, please list below

Allergic to	Reaction

Have you and/or your partner traveled out of the country in the last 6 months? YES NO

Have you been exposed to anyone with active COVID-19 in the last 2 weeks? YES NO

MEDICAL HISTORY

Have you had any of the following problems with a prior pregnancy? Circle any that apply now or in the past and add the dates (if known).

OB History

Anemia

Depression

Excessive bleeding

Pre-eclampsia (high blood pressure)

Excessive bleeding

Preterm labor

Incompetent cervix

Premature rupture of membranes

Infertility

RH negative

Other (describe)

_____

Infections

Previous baby treated for Group B Strep

Trichomonas

Chickenpox illness

Chickenpox immunization

Hepatitis B

Hepatitis C

Other liver problem _____

AIDS /HIV

Herpes (you or your partner)

Yeast

Rubella (german measles)

Condylomata (genital warts)

Cytomegalovirus (CMV)

Syphilis

Gonorrhea

Chlamydia

Heart/Blood/Lung Problems

Anemia

High blood pressure

Blood clots (where?_____)

Blood disorders

Rheumatic heart disease

Blood transfusion

Valve disease

Heart disease

Varicose veins (where?_____)

Asthma

Other lung disease (describe)

Endocrine Problems

Diabetes

Hyperthyroidism

Hypothyroidism

Other endocrine/hormone problem (describe)

GYN History

Abnormal PAP – describe

Other problem related to your cervix

Fibroids

Uterine malformation

GYN surgery (describe)

Kidney/Bladder Problems

Asymptomatic bacteriuria

Bladder infections

Chronic kidney disease

Kidney infection

Kidney stones

Neurological Problems

Migraines

Stroke

Seizure disorder

Psychological History

Addiction (Alcohol) (nicotine) (drugs)

Emotional Abuse (when? by whom?)

Physical Abuse (when? by whom?)

Psychiatric illness

Depression

Anxiety

Other Problems

Autoimmune Disease

Cancer

Major accidents

Anesthetic complications

Gastrointestinal problem (describe)

Current Pregnancy

Since your last period, have you had:

Abdominal Pain

Radiation

Rash w/viral illness

Exposure to tuberculosis

Dizziness

Toxoplasmosis fever

Urinary complaint

Headache

Vaginal bleeding

Vomiting

Viral Exposures - HIV, HSV, HepB

Occupational chemicals

Vision change

GENETIC SCREENING

Have you ever been tested for cystic fibrosis, spinal muscle atrophy or hemophilia or hemoglobinopathy? YES NO

Will you be 35 or older by your due date? YES NO

If you, the baby's father, brother or sister or parent of either relative has or has had the following problems, please circle:

- Thalassemia
- Neural tube defect
- Born with a heart defect
- Down syndrome
- Tay Sachs disease
- Canavan disease
- Hemophilia or bleeding disorder
- Fragile X
- Two or more miscarriages
- Preterm labor
- Cystic Fibrosis
- Huntington's Disease
- PKU
- Juvenile Diabetes
- Muscular Dystrophy
- Sickle Cell disease or trait
- Mental retardation
- Other birth defect
- Stillbirth

DIABETES RISK ASSESSMENT

Do you have a history of pregnancy diabetes? YES NO

Does your parent or sibling have diabetes? YES NO

Do you have a personal history of metabolic syndrome, PCOS, high cholesterol or heart disease? YES NO

Did you have a child weighing more than 9 pounds? YES NO

Do you have any of the following ethnicities? (circle if yes)

- Hispanic
- African American
- South or East Asian
- Native American
- Alaskan
- Hawaiian
- Pacific Islander

SOCIAL HISTORY

Do you plan to deliver at Marshall Medical Center? YES NO

Do you plan to breastfeed? YES NO

Are you considering having your tubes tied after delivery? YES NO

If you have cats, is someone else doing litter box care? YES NO NO CATS

Are you able to get to your appointments without difficulty? YES NO

Do you feel safe where you live? YES NO

Have you always been free from sexual assault? YES NO

Have you been safe from physical assault in the last year? YES NO

Do you have a primary care doctor? YES NO

Do you have regular dental care? YES NO

Do you have a pediatrician chosen for your baby after delivery? YES NO

How many times have you moved in the last 12 months? _____

How do you rate your current stress level on a 1-5 scale? 1 2 3 4 5

If you could change the timing of this pregnancy, would you want it (circle):
earlier later not at all no change

Have you ***ever*** used any type of nicotine product or tobacco? YES NO
If yes, what type _____ amount per day_____ For how many years_____
Quit date (if applicable)_____

Do you use alcohol? YES NO
If yes, how many drinks per day_____ For how many years_____

Do you use other drugs? YES NO
If yes, what type _____ amount per day_____ For how many years_____
Quit date (if applicable)_____

Name of baby's father_____ Are you together? Are there any issues with your relationship that we should be aware of? (divorce, restraining order, etc?)

Do you have any questions for us?

_____

_____