Prepare For Your First Ob Visit

Please read and fill in the answers to these questions to the best of your ability so we can review them at your prenatal visit.

Date of your last menstrual period? _____

Past Pregnancies
Total number of pregnancies:
Full term_____
Premature_____
Miscarriages_____
Induced abortions_____
Ectopic pregnancies_____
Multiple births_____
Number of living children_____

Date of Birth	Gest. age at birth (weeks)	Length of labor (hours)	Birth weight	Sex	Type of delivery	Anesthesia	Place of delivery	Complication

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Medical History

(Please circle if you have had any of the following)

Diabetes mellitus

High blood pressure (hypertension)

Heart disease

Autoimmune disease (lupus,multiple sclerosis, inflammatory bowel disease)

Kidney disease or urinary tract infection

Neurologic disease or epilepsy

Psychiatric disorder

Depression including postpartum depression

Hepatitis or liver disease

Varicose veins or blood clots in the legs

Thyroid disease

Trauma or violence

Lung disease, such as asthma

Rh sensitization

Seasonal allergies

Breast disease

Surgery

Gynecologic disorders

Abnormal pap test result

Infertility

Assisted reproductive technology treatment

Uterine abnormalities

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Lifestyle issues

Smoking

Did you smoke before pregnancy?	Yes	No
Do you smoke now?	Yes	No

Alcohol

Did you drink alcohol before pregnancy?	Yes	No
Do you drink alcohol now?	Yes	No

Illegal Drugs

Did you use illegal drugs before pregnancy?	Yes	No
Do you use illegal drugs now?	Yes	No

Your Home life

Do you feel safe in your current living situation?	Yes	No
Do you feel safe with your current partner?	Yes	No

If you answered "No" to either of these questions, please exercise caution and do not leave this form where your partner may see it. Both you and your baby may be at risk in this situation. It is important that you protect yourself and your baby by finding a safe place.

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Genetic background

Please indicate whether you or your baby's father, or anyone in either family has had any of the following conditions:

Condition	Yes	No
Thalassemia (Italian, Greek,Mediterranean, or Asian background)		
Neural tube defect (Spina bifida, meningomyelocele, anencephaly)		
Congenitaal heart defect		
Down syndrome		
Tay-Sachs disease(Ashkenazi Jewish, Cajun,French, Canadian)		
Canavan disease (Ashkenazi Jewish)		
Familial dysautonomia (Ashkenazi Jewish)		

Have your or baby's father had a child with a birth defect not listed above?

If yes, what type?

Are you 35 years or older?

Do you have a metabolic disorder, such as type 1 diabetes mellitus or phenylketonuria?

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Medications

Please list all medications you have taken since your last menstrual period (including supplements, vitamins, herbs, and over the counter drugs). Please include strength and dosage.

Drug	Strength (mg)	Dosage

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Infection History

Do you live with someone with tuberculosis or have you been exposed to tuberculosis? Yes No

Do you or your partner have oral or genital herpes? Yes No

Have you had a rash or viral illness since your last menstrual period? Yes No

Do you have hepatitis B virus or hepatitis C virus? Yes No

Have you ever had the following childhood diseases or have you been vaccinated against them?

Chickenpox	Yes	No	Vaccine
Measles	Yes	No	Vaccine
Mumps	Yes	No	Vaccine
Rubella	Yes	No	Vaccine

Have you had parvovirus? Yes No

Have you ever had a sexually transmitted disease? Yes No

Please circle all that apply:

Gonorrhea

Chlamydia

Human immunodeficiency virus (HIV)

Syphilis

Human papillomavirus (HPV) infection