Next Generation
WOMEN'S IMAGING AND MATERNAL-FETAL MEDICINE

OB HISTORY FORM

Please help us to learn more about your previous pregnancies, medical and family conditions by accurately filling out this form. The more we know about you, the better we can care for you. Thank you.

Name:_____ **Referring MD:**_____

Age: _____ **Birthday:**_____ **Height:**_____ **Weight:**_____

Due date:_____ **First day of last period?**_____

How many living children do you have? _____
Number of vaginal deliveries? _____
Number of cesarean deliveries? _____
Number of pregnancy terminations? _____
Number of miscarriages? _____
Have you had any GYN surgery? (what kind/when?)_____
_____

Have you had any abnormal screening tests in this pregnancy?_____
_____

Please answer yes or no:	NO	YES
Was this pregnancy conceived through IVF?		
Have you had an ectopic pregnancy before?		
Have you had a previous pregnancy with Pre-eclampsia?		
Stillbirth?		
Small baby?		
Big Baby?		
Excessive bleeding?		
Preterm birth?		
Diabetes?		
Recurrent miscarriage?		
Too much or too little amniotic fluid?		
Do you have (or have you ever had) high blood pressure?		
Do you have diabetes or problems with your blood sugar?		
Have you ever had a blood clot/ DVT or PE (pulmonary embolus)?		
Do you have a thyroid problem?		
Have you been diagnosed with cancer?		
Do you have lupus or any other rheumatologic problem?		
Do you have heart disease?		
Do you have epilepsy (or recurrent seizures)?		
Do you have a thrombophilia or a bleeding disorder?		
Do you travel frequently to ZIKA endemic areas?		
Are you a smoker?		
Have you consumed alcohol in this pregnancy?		

What medicines are you taking? _____

Have you had any surgery? (what kind?)_____

Do you or the father of the baby have a personal or family history of any of these conditions?

Please answer yes or no:	NO	YES
Down syndrome?		
Other chromosome problem?		
Mental retardation or autisim?		
Spina Bifida (open spine)?		
Anencephaly (opening in head/brain)?		
Blood Disorder (such as hemophilia or sickle cell)?		
Cystic fibrosis?		
Muscular Dystrophy or neuromuscular disease?		
Neurofibromatosis?		
Have you had a previous baby with a birth defect?		
Skeletal disorder like dwarfism?		
Polycystic kidney disease?		
Heart defect at birth?		
Cleft lip/cleft palate?		
Baby who died after birth or within first year?		
Any birth defect not listed above?		
Any other inherited condition or genetic problems?		
Are you or the father of the baby adopted?		
Are you and the father of the baby related to each other?		
Did you use an egg or sperm donor?		
Did you have a CAT scan in this pregnancy?		

Anything else you think we should know? _____

_____

_____

_____

I answered these questions to the best of my knowledge because I know that it is important for my pregnancy.

Signature: _____

Print name: _____

Date: _____

Thanks for taking the time to fill this out.