NIX HEALTH CARE SYSTEM

OBSTETRICAL HISTORY

NAME: _____ 1ST day of last menstrual period: ____/____/____

Normal? ☐ Yes ☐ No Month Day Year

DEMOGRAPHIC DATA

Age	Date of Birth	Home Phone	Work Phone	Place of Birth

Ethnicity	Marital Status	Occupation	Education Completed
W B H Other _____	S M D W Sep Remarried		

Father of Baby's name	Telephone	Occupation

Person to Notify in Emergency	City, State	Home Phone	Work Phone

INSURANCE: _____

PAST PREGNANCIES

Date Month/Year	Place of Delivery	Months or Weeks	Vaginal or Cesarean	Infant's Sex (M-F)	Birth Weight	Pre-Term Labor (Yes-No)	Health Status	Complications/Comments

PAST MEDICAL HISTORY

	No	Yes
Cancer		
High blood pressure		
Heart/valve disease		
Rheumatic fever		
Lung disease		
Breast disease or problems		
Liver disease		
Gallstones/gallbladder disease		
Diethylstilbestrol (DES) exposure		
Stomach/bowel problems, (including peptic ulcer disease)		
Kidney disease		
Urinary problems, infections, or malformations		
Diabetes mellitus		
Thyroid disease/other		
Other endocrine disorders		

	No	Yes
Lupus (SLE)		
Nervous/mental disorders		
Epilepsy		
Stroke		
Anemia/blood disorders		
Blood clots or emboli		
Phlebitis		
Blood transfusion Year_____		
Major joint or bone problems		
Other:		

INFECTIOUS DISEASE HISTORY

	No	Yes
Hepatitis		
Tuberculosis		
Genital Warts (Condyloma)		
Dysplasia (HPV)		
HIV (AIDS)		
Chlamydia		
Gonorrhea		
Syphilis		
Genital Herpes		
Trichomoniasis		
Pelvic Inflammatory Disease (PID)		
Other:		

GENETIC HISTORY

(Includes patient, father of baby, and both families)

	No	Yes
Patient at 34 years		
Italian, Greek, Mediterranean or Oriental Background (MCV ≤ 80)		
Jewish descent (Tay Sachs)		
Sickle cell disease or trait		
Hemophilia		
Muscular Dystrophy		
Cystic Fibrosis		
PKU		
Down's Syndrome		
Neural tube defect (spina bifida, anencephaly, meningomyelocele)		
Mental retardation		
Other birth defects or inherited diseases		

SURGERIES/HOSPITALIZATIONS

(excluding childbirth)

CURRENT MEDICATIONS

(Include all prescription and nonprescription drugs taken since pregnancy began)

ALLERGIES TO MEDICATIONS

YEAR	OPERATION/ILLNESS/INJURY	MEDICATION	DRUG	REACTION
1.		1.	1.	
2.		2.	2.	
3.		3.	3.	
4.		4.	4.	

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I HAVE NOT WITHELD ANY INFORMATION.

SIGNATURE: _____ DATE: _____