GREENBRIER OBSTETRICS AND GYNECOLOGY, P.C.

Obstetrical Form

Name: _____ DOB: _____ Age: _____

Race: _____ Ethnic Origin: _____ Primary Care Physician: _____

Allergies: _____ Latex Allergy: **YES / NO** Iodine Allergy: **YES / NO**

Medications: _____

Marital status: **Never Married / Married / Divorced /Legally Separated / Widowed**

PAST MEDICAL HISTORY

Last Pap smear: _____ Result: _____ Have you ever had an abnormal pap smear? **YES / NO**

If so, when? _____ Treatment received: _____

Have you ever had (Please circle):

Chlamydia	HPV	Heart disease	Liver Disease	Seizures
Gonorrhea	Uterine fibroids	High blood pressure	Thyroid Disease	Incompetent cervix
PID	PCOS	Blood clot in lung/leg	Diabetes	Chicken pox
HIV	Endometriosis	Cystitis	Anemia	Viral illness since LMP
Trichomonas	Abnormal uterus	Kidney problems	Ovarian Cyst	Pregnancy induced hypertension
Hepatitis B	DES exposure	Bladder problems	Asthma	Premature rupture of
Hepatitis C	Ectopic pregnancy	Migraine	Tuberculosis	Gestational Diabetes
Syphilis	Breast Cancer	Depression	Sickle cell trait	Polyhydramnios
Genital herpes	Uterine Cancer	Anxiety	Sickle cell disease	Intrauterine growth retardation
Genital warts	Ovarian Cancer	Bipolar disorder	Lupus	Toxoplasmosis
	Rh Isoimmunization	Group Beta strep	Hyperemesis	Exposure to harmful substances

Have you ever had a blood transfusion? **YES / NO if** yes, date: _____

Other on-going medical conditions not listed: _____

Are you of Ashkenazi Jewish Descent? _____

MENSTRUAL HISTORY

First day of last menstrual period (LMP):_____ x _____ days LMP date is: **Definite / Unsure**

Number of days between cycles: _____ Flow amount: **Light / Moderate / Heavy**

Age at first menstrual period: _____ Were you on birth control at conception? **YES / NO Type:** _____

Types of other birth control used in the past: Pills Depo Provera IUD Patch Ring Condoms

PREGNANCY HISTORY

Total # of pregnancies (**including this pregnancy**):_____ Live births: _____ Losses: _____ Terminations: _____

# of Vaginal: _____ Dates: _____ # of C-section:_____ Dates: _____

Dates of pregnancy losses: _____ Dates of terminations: _____

Did you have any complications with any of your pregnancies? **YES / NO**_____

SURGICAL HISTORY

Have you ever had any problems with anesthesia? YES / NO _____

C-Section	Laser surgery	Removal of ovary	Breast Augmentation	Appendectomy
Colposcopy	D&C	Removal of ovarian cyst	Breast Reduction	Bladder surgery
Cervical biopsy	Hysteroscopy	Uterine ablation	Breast biopsy	Tonsillectomy
LEEP	Laparoscopy	Fibroid embolization	Lumpectomy	Wisdom tooth
Cone biopsy	Induced abortion	Myomectomy	Mastectomy	Hernia repair
Cryosurgery	Removal of tube	Tubal ligation	Gallbladder removal	Gastric bypass

Other surgeries: _____

SOCIAL HISTORY

Occupation: _____

Have you ever smoked cigarettes or tobacco? **YES / NO**

Do you **currently** smoke? **YES / NO** Amount per day: _____

If **former smoker**, age you quit smoking: _____

Do you use recreational or illicit drugs? **YES/NO** Type: _____

Do you drink alcohol? **YES / NO** Frequency: _____

Do you exercise? **YES / NO**

Do you drink caffeine? **YES / NO**

Do you follow a diet? **YES / NO**

Do you have any pets? **YES / NO If** yes, please list:_____

Have you had more than one sexual partner in the last year? **YES / NO**

Have you ever been physically or sexually abused? **YES / NO**

Do you have any religious objections to blood transfusion? **YES / NO**

FAMILY HISTORY: (Patient's family members/relatives only)

Anemia:_____ Menstrual problems:_____ High blood pressure:_____

Twin pregnancy:_____ Thyroid disease:_____ Tuberculosis:_____

Depression:_____ Kidney disease:_____ Psychiatric prob:_____

Diabetes:_____ Heart disease:_____ Blood clot in lung/leg:_____

Endometriosis:_____ High cholesterol:_____ Stroke:_____

Do you have any family history of cancer? YES / NO Please list:_____

GENETIC SCREENING: (Patient, baby's father or anyone in either family)

Thalassemia	Tay-Sachs	Huntington's disease	Familial dysautonomia
Spina Bifida	Canavan disease	Mental retardation/Autism	Infertility
Anencephaly	Sickle cell trait or disease	Inherited or chromosomal disorder	Twins/Triplets
Meningomyelocele	Hemophilia/Blood disorders	Repeated pregnancy loss/stillbirth	Neurofibromatosis
Congenital heart defect	Muscular dystrophy	Cerebral palsy	Niemann-Pick disease
Down Syndrome	Cystic Fibrosis	Cleft lip or cleft palate	Osteogenesis Imperfecta
PKU	Prader-Willi syndrome	SIDS	Immunodeficiency

REVIEW OF SYSTEMS: Please circle symptoms that you are currently having.

General/Constitutional
Dizziness
Fatigue
Weakness
Fever
Change in appetite
Recent weight change
Mood change
Difficulty sleeping
Fetal movement
Contractions
Ruptured membranes

Ear, Nose, Throat
Vision problems
Nose bleeds
Mouth or teeth problems
Difficulty swallowing

Cardiovascular/Respiratory
Chest pain
Shortness of breath
Palpitations

Gastrointestinal
Nausea
Vomiting
Abdominal pain
Heartburn
Constipation
Diarrhea
Blood in stool

Genitourinary
Vaginal bleeding
Pelvic pain/Cramping
Vaginal discharge
Vaginal itching
Vaginal odor
Painful urination
Urinary urgency
Night time urination
Losing control of urine
Blood in urine
Genital sores

Musculoskeletal
Joint or muscle pain
Muscle weakness
Back pain

Integumentary
Breast lump/mass
Breast pain
Nipple discharge
Varicose veins

Neurological
Numbness/Tingling
Headaches
Seizures
Tremors
Difficulty walking
Localized weakness

Psychiatric
Anxiety
Depression
Suicidal thoughts
Homicidal thoughts

Endocrine
Excessive appetite
Excessive thirst
Excessive urination
Heat/Cold intolerance

Hematologic
Easy bleeding/bruising
Swollen glands