

OBSTETRICAL DATABASE

GENERAL INFORMATION

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Work/Other Phone Number: _____

Birthdate: _____ Age: _____

Referred By: _____

Religion: _____

Marital Status: Single Married Divorced Widowed Other: _____

Your Occupation: _____

Partner Occupation: _____

Education Level: 10 11 12 College 1 2 3 4 4+ Other: _____

Hobbies: _____

GYN HISTORY

Age at onset of menstruation: _____

Number of days between typical period: _____

Are you menstrual periods usually regular? Yes No If no, please explain: _____

Date of your last menstrual period? _____

What form of contraception have you used in the past? Birth Control Pills, IUD,
Diaphragm, DepoProvera, Norplant, Rhythm Method, Condoms or Abstinence.

Have you ever been treated for any sexually-transmitted diseases? Chylamydia,
Gonorrhea or Herpes? _____

Have you ever had an IUD? If yes, date removed?: _____

Have you ever had an abnormal pap? If yes, please explain: _____

Have you ever had any surgery on your female organs? If yes, please explain and give dates: _____

Did your mother take DES when she was pregnant with you? Yes No

When was the first day of your last period?: _____

Is this a planned pregnancy?: Yes No

How tall are you?: _____

What is your partner's weight and height?: _____

Is this your partner's first baby?: _____

Have you had a problem with infertility in the past?: Yes No If yes, please explain: _____

Have you taken any drugs for fertility in this pregnancy?: Yes No If yes, please explain: _____

Have you had any of the following symptoms during this pregnancy that have been a significant problem for you?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Nausea: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue: _____
<input type="checkbox"/>	<input type="checkbox"/>	Burning with urination: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal or pelvic pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal discharge: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vulvar itching or irritation: _____
<input type="checkbox"/>	<input type="checkbox"/>	Sore breasts: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge or breast lump: _____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever or chills: _____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath: _____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeats: _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion, heartburn or abdominal pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools: _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression: _____
<input type="checkbox"/>	<input type="checkbox"/>	Change in a mole: _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in swallowing: _____
<input type="checkbox"/>	<input type="checkbox"/>	Leg or hand swelling: _____
<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids: _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to rubella or other viral illnesses: _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any drugs: _____
<input type="checkbox"/>	<input type="checkbox"/>	Prescription drugs: _____
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drugs: _____

Have you had any X-rays or other radiation exposure during this pregnancy?: Yes No

If yes, please explain: _____

MEDICAL HISTORY

Are you allergic to any drugs?: Yes No What happened?: _____

Have you had any of the following?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Serious accident or illness: _____
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic or hip fracture: _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion: _____

Have you had any of the following problems?

<u>Yes</u>	<u>No</u>	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous or mental problem: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic complications: _____
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection: _____
<input type="checkbox"/>	<input type="checkbox"/>	German measles: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures: _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches: _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems: _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure: _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast abnormalities: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: _____
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones: _____
<input type="checkbox"/>	<input type="checkbox"/>	Deep venous thrombosis (blood clots in your legs): _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding abnormalities: _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis: _____

HABITS

<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	When was the last time you had a cigarette? _____ How many packs do you smoke a day? _____ How old were you when you started smoking? _____
<input type="checkbox"/>	<input type="checkbox"/>	When was the last time you had a drink of alcohol? _____ What is the average number of drinks per week? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used street drugs? _____ Marijuana, cocaine, crank? Have you ever put drugs in your veins? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your partner a heavy drinker? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt you ought to cut down on your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have people annoyed you by criticizing your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever felt bad or guilty about your drinking? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener)
<input type="checkbox"/>	<input type="checkbox"/>	Do you use seatbelts? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly? _____

SOCIAL HISTORY

<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Are there any family or social problems you feel I should know about? Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your partner supportive of your pregnancy? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does he plan to be present with you at your baby's birth? _____

FAMILY HISTORY

Do any of the following disease run in your family?

<u>Yes</u>	<u>No</u>	If yes, please describe type and relative involved:
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis: _____

FAMILY HISTORY (cont.)

- Do any of your relatives have Down's Syndrome (Mongolism) or any other chromosomal abnormalities that you know of?
- Are there any twins in your family?
- Does any member of your extended family have a cleft lip or palate, pyloric stenosis, congenital heart disease, neural tube defects (Spina Bifida or other types), clubbed feet, Cystic Fibrosis, PKU, Muscular Dystrophy, Hemophilia or any other known birth defects or abnormalities?
- Did any of your relatives require surgery in the first year of life?
If yes, please describe: _____
- Is there a family history of mental retardation?
- If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
- If you or the baby's father are black, have either of you been screened for sickle cell trait?
- If you or the baby's father are Italian, Greek or Mediterranean background, have either of you been tested for β -thalassemia?
- If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for α -thalassemia?
- Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (including nonprescription drugs)?
If yes, give name of medication and time taken during pregnancy: _____

PAST PREGNANCIES:

1. Please describe all your prior pregnancies, including date, live birth (yes or no), sex of child, name of child, weight of child, hospital where child was born, method of delivery (C-section or vaginal) any pre-term labor with the pregnancy and any complications during pregnancy, labor or delivery.

	First	Second	Third	Fourth	Fifth
Date					
Live birth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>
Name					
Weight					
Place of birth					
Duration of active labor					
Any complications during pregnancy, labor or delivery (please describe)					

(If more than five pregnancies, please complete on separate sheet)

Who is going to be your baby's doctor?: Pediatrician _____ Family doctor _____

Are you going to: Breast feed? Bottle feed?

Is there anything about your prior pregnancy (or pregnancies), labor or delivery experiences you would or would not want repeated?: (please explain) _____

Is there anything else you feel your doctor should know about you, your partner or your family? _____