Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

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OBSTETRICAL DATABASE

GENERAL INFORMATION

Name: _____ Date: _____

Birthdate: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Work/Other Phone Number: _____

Referred By: _____ PCP: _____

Religion: _____

Your Occupation: _____

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

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____

Partner Name: _____ Partner Occupation: _____

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: _____

First day of your last menstrual period? _____ Certain: Yes ❑ No ❑

Is this a planned pregnancy?: Yes ❑ No ❑

What form(s) of contraception have you used in the past? Birth Control Pills, IUD, Nexplanon, Depo, Diaphragm, Rhythm Method, Condoms or Abstinence.

Recent IUD? If yes, date removed?: _____

Have you ever been treated for any sexually-transmitted infections? Chlamydia, Gonorrhea, Herpes, Trichomonas, Syphilis?

When/where was your last pap smear? _____

Have you ever had an abnormal pap smear? 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 ❑ Uncertain ❑

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?

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

Have you had any X-rays or other radiation exposure during this pregnancy?: Yes ❑ No ❑
If yes, please explain:

Vaccine History:
Flu Shot Yes ❑ No ❑ When:
Gardasil Yes ❑ No ❑ When:
Tetanus Yes ❑ No ❑ When:

MEDICAL HISTORY

❑ ❑ 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:

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

Latex Allergy?: Yes ❑ No ❑

Have you had any of the following?

Yes	No	If yes, please describe:
❑	❑	Serious accident or illness:
❑	❑	Pelvic or hip fracture:
❑	❑	Blood transfusion:

Have you had any of the following problems?

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

HABITS

Yes	No	
❑	❑	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? _____
❑	❑	When was the last time you had a drink of alcohol? _____ What is the average number of drinks per week? _____
❑	❑	Have you ever used street drugs? _____ Marijuana, cocaine, crank? Have you ever put drugs in your veins? If yes, please explain:
❑	❑	Is your partner a heavy drinker?
❑	❑	Have you ever felt you ought to cut down on your drinking?
❑	❑	Have people annoyed you by criticizing your drinking?
❑	❑	Have you ever felt bad or guilty about your drinking?
❑	❑	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener)
❑	❑	Do you use seatbelts?
❑	❑	Do you exercise regularly?

SOCIAL HISTORY

Yes	No	
❑	❑	Are there any family or social problems you feel I should know about? Explain:
❑	❑	Is your partner supportive of your pregnancy?
❑	❑	Does he plan to be present with you at your baby's birth?

FAMILY HISTORY

Do any of the following diseases/conditions run in your family?

Yes	No	If yes, please describe type and relative involved:
❑	❑	Cancer:
❑	❑	Diabetes:
❑	❑	Tuberculosis:

FAMILY HISTORY (cont.)

❑ ❑ Do any of your relatives have Down's Syndrome 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 delays or deficits?

❑ ❑ 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?

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 ❑	No ❑	Yes ❑	No ❑	Yes ❑	No ❑	Yes ❑	No ❑	Yes ❑	No ❑
Sex	M ❑	F ❑	M ❑	F ❑	M ❑	F ❑	M ❑	F ❑	M ❑	F ❑
Name										
Weight										
Gestational Age										
Epidural										
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?_____