OB COMPREHENSIVE MEDICAL HISTORY **Name** _____

Medical History				
Have you Had?	**If Yes, Date**		**Have you Had?**	**If Yes, Date**
Anemia			HIV	
Anesthesia complications			Infertility	
Anorexia			Kidney problem/disease *(specify)*	
Arthritis			Kidney infection	
Asthma			Liver problem/disease *(specify)*	
Autoimmune disease			Lung problem/disease *(specify)*	
Birth defects			Major accident	
Bladder infection			Measles	
Blood disorders/disease *(specify)*			Migraines	
Blood transfusion			Mitral Valve Prolapse	
Cancer *(specify)*			Mono	
Chickenpox			Ovarian Cysts/growths	
Chlamydia			Infection of uterus/tubes/ovaries	
Depression			Psychiatric disorder *(specify)*	
Deep Vein Thrombosis			Rheumatic fever	
Diabetes			Syphilis	
Epilepsy			Thyroid problems/disease *(specify)*	
Gastrointestinal problem/disease			Tuberculosis	
Genital herpes			Varicose Veins	
Genital warts			Abnormal Pap Smear	
Gonorrhea			Uterine growths/fibroids	
Hay fever/seasonal allergies			Uterine/Cervical Abnormality	
Heart Problem/disease *(specify)*			Pap Smear *(Date of last pap)*	
Hepatitis *(specify type)*			Mammogram *(Date of last Mammo)*	
High blood pressure			Thyroid testing *(Date of last testing)*	

Your family doctor: _____ Pediatrician: _____

Surgical History	
Date	**List of all previous hospitalizations, surgeries, and procedures**

Are you adopted? ☐ **No** ☐ **Yes** **If yes, do you know your family history?** ☐ **No** ☐ **Yes**

Family Medical History					
Has any blood relative ever had:	**Maternal Relative** *(If Yes, Specify)*	**Paternal Relative** *(If Yes, Specify)*	**Has any blood relative ever had:**	**Maternal Relative** *(If Yes, Specify)*	**Paternal Relative** *(If Yes, Specify)*
Asthma			Hay fever/Allergies		
Birth Defect			Heart disease *(specify)*		
Blood Disorder			Hepatitis *(specify type)*		
Cancer *(specify)*			High blood pressure		
Deep Vein Thrombosis			Liver disease		
Diabetes			Kidney disease *(specify)*		
Gastrointestinal Disease			Psychiatric disease		
Goiter			Thyroid disease		
			Tuberculosis		

Genetic History		
Please check if you, your partner, your blood relatives, or his blood relatives ever had:		
	Yourself	**List Family Member**
Cerebral Palsy	☐	
Congenital birth defects	☐	
Cystic fibrosis	☐	
Down syndrome	☐	
Mental retardation	☐	
Neural tube defect	☐	
Sickle cell disease	☐	
Twins	☐	
Triplets	☐	
Are you and your partner blood relatives?	☐	

Your ethnic background:	**Your partner's ethnic background:**
Father of your baby's name:	**Relationship:**
How old is the father of your baby?	**Is this your first child together?** ☐ **YES** ☐ **NO**

Social History

Highest Level of Education	
Grade School	years
High School	years
College	years
Postgraduate	years

Religion _____

Occupation _____

Do you have cats? ☐ YES ☐ NO

Marital Status (circle)

☐ Single ☐ Married

☐ Engaged ☐ Divorced

Substance Use	Never	Usual amount used before pregnancy	Amount used since known to be pregnant
Caffeine	☐		
Tobacco	☐		
Alcohol	☐		
Drugs	☐		

Have you ever used drugs or alcohol during pregnancy? ☐ YES ☐ NO

Have you had a problem with drugs or alcohol in the past? ☐ YES ☐ NO

In the month before you knew you were pregnant how often did you use? _____

Does your partner have a problem with drugs or alcohol? ☐ YES ☐ NO

Do you consider one of your parents to be an addict or alcoholic? ☐ YES ☐ NO

Sexual History					
More than one partner in the last 12 months?	☐ YES	☐ NO	**History of sexual abuse?**	☐ YES	☐ NO
More than 3 partners in lifetime?	☐ YES	☐ NO	**History of physical abuse?**	☐ YES	☐ NO

Pregnancy History **Have you ever been pregnant?** ☐ **YES** ☐ **NO** **Please list all pregnancies**

Delivery Date	Mo. Along	Vag. or C-Section	Complications	Living Y/N

Have you ever had a miscarriage or abortion? ☐ **YES** ☐ **NO** **Please list all miscarriages**

Date	Wks Along	Miscarriage	Abortion	Complications
		☐	☐	
		☐	☐	
		☐	☐	

Menstrual History

First day of your last period? **Are you certain?** ☐ YES ☐ NO **Did you have a normal flow?** ☐ YES ☐ NO

How often do you have periods? Every _____ days

How long do they last? _____ days

Typical Flow (circle): ○ Light ○ Moderate ○ Heavy

Age at very first period:

Last contraceptive used:

When?

Have you had a positive home pregnancy test? ☐ YES ☐ NO

If so, when?

Have you had an HCG or progesterone test done with this pregnancy? ☐ YES ☐ NO

Have you had a flu shot this year? ☐ YES ☐ NO

Have you had a COVID vaccine? ☐ YES ☐ NO

Current Pregnancy History

In *this* pregnancy, have you had:	If yes, please give details
Headaches	
Dizziness	
Nausea	
Vomiting	
Vaginal Discharge	
Vaginal spotting or bleeding	
Urinary Complaints	
Swelling of feet, ankles, hands, or face	
Fever	
Cold or Flu	
Rash	
Exposure to X-ray	
Exposure to communicable disease	
Non-prescription drugs	
Prescription drugs	

Preferred Pharmacy: **What was your weight when you got pregnant?**

List all current medications: _____

List all medication allergies: _____