MID-KANSAS WOMEN'S CENTER, PA
OB HISTORY FORM

Congratulations on your recent pregnancy! In order to expedite your first OB visit, please complete the following history.

Date_____________________

Provider (circle one): **Agustin** **DeHart** **Lopez** **Rogers**

Patient Name________________________________ **Date of Birth**___________________

Address____

City__________________________________ **State**___________ **Zip Code**___________

Phone (H) _________________ **(W)**___________________ **Cell** ___________________

Occupation ______________________________ **Last Grade Completed**______________

Preferred Pharmacy _________________________ **Location** ______________________

Preferred Hospital for Delivery ____

Husband/Father of Baby ____________________________ **Phone** __________________

Emergency Contact _________________________________ **Phone**__________________

What was the first day of your last menstrual period? _____________________________

How certain are you about this date? (Please check one)

____**Definite** _____**Plus/Minus a few days** ____**Know the month** _____**Guess**

Was this a normal period for you? ____**No** ____**Yes**

Were you on birth control pills at the time? ____**No** ____**Yes**

When did you have a positive pregnancy test? ____________________________________

What did you weigh before pregnancy? ___________ **How tall are you?** ___________

Pregnancies/Birth History/Abortions/Terminations:							
Date	Gestational Age (Wks)	Length of Labor	Baby Weight (lbs/oz)	Sex (M/F)	Delivery Type Vaginal / C-Section	Place	Complications

Please check the following if you have or have had the following problems:

_____Diabetes
_____High Blood Pressure
_____Autoimmune Disease
_____Kidney Disease
_____Frequent bladder infections
_____Seizure Disorder
_____Psychiatric Problems
_____Vein Problems/Blood Clots
_____Blood Transfusion

______ Rh Disease
______Lung problems/asthma
______Breast problems or surgery
______History of abnormal pap smears
______DES exposure
______Infertility
______Hepatitis/Liver Disease
______Thyroid Disease
______History of Physical/Sexual Abuse

Surgeries/Procedures (Please list all surgeries and dates)		
Type	When (Date or Year)	Location

Drug Allergies	
Type:	**Reaction:**

Do You smoke? ___No ____Yes How many per day before___ How many after pregnancy?___

Do you drink alcohol? ___No ___Yes How much before ____ How many after pregnancy?___

Do you use or have you ever used street drugs? ___No ___Yes What kind? ___________________
____
What health problems are present in your family? (Include relation) _________________________
____

The following are risk factors for certain genetic diseases. Positive responses may indicate a need for genetic counseling. Please check those that apply to you or are present in the family of the baby's father.

____Italian/Greek, Mediterranean or Asian descent
____Spina Bifida or Anencephaly
____Down Syndrome
____Jewish/Cajun/French Canadian descent
____Sickle cell disease or trait
____Hemophilia
____Muscular dystrophy
____Cystic fibrosis
____Huntington chorea
____Mental retardation
____Other genetic problem
____Other birth defect
____3 or more miscarriages
____Medication/Drug use since pregnancy
____
____

Please check the following if they apply to you:

____risk factors for HIV infection
____risk factors for Hepatitis B
____exposure to TB (tuberculosis)
____exposure to herpes
____rash/viral infection since pregnancy
____prior sexually transmitted disease

We perform HIV Screening on all OB patients unless you decline. Please sign below if you decline HIV screening:

I decline HIV screening ____ ____________ Date
Patient Signature