LEXINGTON Women's Care

A Lexington Medical Center Physician Practice

OB Patient History

Date: _____

Patient's Name: _____ DOB: _____ Age: _____

Referred by: _____ Pediatrician: _____

Primary Care Provider: _____

Race: _____ Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married

Occupation: _____ ☐ Full time ☐ Part time ☐ Unemployed ☐ Student

Primary language: _____ Ethnicity: _____

Education Completed: ☐ High School ☐ Some college ☐ College graduate ☐ Other: _____

EMERGENCY CONTACT

Contact Name	Relation	Contact Number
	Husband/Domestic Partner	
	Father of Baby	
	Other:	

PREVIOUS PREGNANCIES:

Total Number of Pregnancies	
Full Term	
Premature	
Induced abortion	
Spontaneous abortion	
Ectopic pregnancies	
Multiple births	
Living children	

LAST MENSTRUAL PERIOD

☐ Definite Date: _____

☐ Approximate date known: _____

☐ Date unknown

On birth control pill at conception? ☐ Yes ☐ No

Prior menses:

Frequency: every _____ days

Menarche (age of onset): _____

Date of positive pregnancy test: _____

Are blood transfusions acceptable to you if needed? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No

DRUG ALLERGIES

Name of Drug	Reaction	Name of Drug	Reaction

CURRENT MEDICATIONS (prescription first then over the counter medications)

Name of Drug	Strength	Frequency

MEDICAL HISTORY (please check all that apply)

Diabetes	☐ Yes ☐ No	D (RH) Sensitized	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Pulmonary: TB or Asthma	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Seasonal allergies	☐ Yes ☐ No
Autoimmune disorder	☐ Yes ☐ No	Drug/Latex allergy reactions	☐ Yes ☐ No
Kidney disease / UTI	☐ Yes ☐ No	Breast problems	☐ Yes ☐ No
Neurological issues	☐ Yes ☐ No	GYN surgery	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Anesthetic complications	☐ Yes ☐ No
Psychiatric	☐ Yes ☐ No	History of abnormal pap	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Uterine anomaly	☐ Yes ☐ No
Post partum depression	☐ Yes ☐ No	Infertility	☐ Yes ☐ No
Hepatitis / liver disease	☐ Yes ☐ No	Fertility treatment (ART)	☐ Yes ☐ No
Varicosities / Phlebitis	☐ Yes ☐ No	Significant Family History	☐ Yes ☐ No
Thyroid Dysfunction	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No
Trauma / Violence	☐ Yes ☐ No	Other	☐ Yes ☐ No
History of blood transfusion	☐ Yes ☐ No		

Please explain any YES answers: _____

_____

_____

HOSPITALIZATION / SURGICAL HISTORY

Year	Reason	Where (City/State)

SUBSTANCES USED

Name	Amount used pre-pregnancy	Amount used while pregnant	Years used
Tobacco			
Alcohol			
Illicit/Recreational Drugs			

GENETIC SCREENING

Has patient or baby's father had a child with birth defects?	☐ Yes ☐ No
Have you had recurrent pregnancy loss or stillbirth?	☐ Yes ☐ No
Have you taken medications (including supplements, vitamins, herbs or OTC drugs/illicit/recreational drugs or alcohol) since your last menstrual period?	☐ Yes ☐ No

Please explain any YES answers: _____

_____

_____

INFECTION HISTORY

Do you live with someone or have you been exposed to someone with tuberculosis?	☐ Yes ☐ No
Do you or your partner have a history of genital herpes?	☐ Yes ☐ No
Have you had a rash or viral illness since your last menstrual period?	☐ Yes ☐ No
Have you ever been diagnosed with Hepatitis B or C?	☐ Yes ☐ No

Have you had a history of:

STD: ☐ Yes ☐ No Gonorrhea: ☐ Yes ☐ No Chlamydia: ☐ Yes ☐ No

HPV: ☐ Yes ☐ No HIV: ☐ Yes ☐ No Syphilis: ☐ Yes ☐ No

Other:

History reviewed by: _____ Date: _____