

Today's Date: ___/___/___

NEW OB HISTORY

Southwest Women's Care

Kimberly M. Balk, MD
Jamal Mourad, DO
Tiffany M. Simpson, WHNP-BC

Robert C. Grayson, MD
Mo R. Vaziri, MD
Holly L. Campbell, FNP-BC

Laura T. Kimbro, DO
Amy J. Williamson, MD
Karen S. Pettit, RNFA

Stephanie C. Mayes, MD
Richard W. Wilson, MD

40th St & Pecos

16611 S. 40th St., Suite 180
Phoenix AZ 85048
480.785.2100 Phone
480.785.2111 Fax

Dobson & Baseline

2204 S. Dobson Rd., Suite 202
Mesa, AZ 85202
480.222.0699 Phone
480.222.0706 Fax

Patient Name: _____ Date of Birth: ___/___/___

Current Medications: _____

Allergies: _____

Occupation: _____ Marital Status: _____

Racial Background: Patient: _____ Father: _____

OB History

Age of first menses: _____ Last Menstrual Period: ___/___/___ Normal Period? **Y N**

Length of Period: _____ Are your periods regular? **Y N** How often do you have periods? _____

On birth control pills? **Y N** If yes, name: _____ Conception Date (if known): ___/___/___

Date of positive pregnancy test: ___/___/___ **Urine** or **Blood**

Weight before pregnancy: _____ Have you had care for this pregnancy with another doctor? **Y N**

If yes, when was your first visit there? ___/___/___ Doctor's Name: _____

Family OB History

Your weight at birth: _____ lbs _____ oz Father of baby weight at birth: _____ lbs _____ oz

Highest birth weight of any of your children: _____ lbs _____ oz

Any history of traumatic birth in close family members? **Y N** Comments: _____

Previous Pregnancies

Total # of pregnancies: _____

of Full-term deliveries: _____

of premature deliveries (before 37 weeks): _____

of Abortion(s): _____

of Miscarriage(s): _____

of Ectopic pregnancy(ies): _____

Any multiples? _____

How many living children do you have? _____

Patient Name: _____

Today's Date: ____/____/____

Past Pregnancy Information:

Pregnancy #	1	2	3	4	5	6	7
Delivery Date							
Time							
# of Weeks							
Vag / C-section							
Anesthesia							
Length of Labor							
Place of Birth							
Doctor							
# of Babies							
Weight							
Sex							
Liveborn?							
Complications							
Baby's Name							

Medical History

Comments

Medical History

Comments

Y N Anemia/Hematologic _____
 Y N Asthma/Pulmonary _____
 Y N Autoimmune Disorder _____
 Y N Abnormal Pap Smears _____
 Y N Blood Transfusion _____
 Y N Breast Disorder _____
 Y N Depression _____
 Y N Psychiatric Disorder _____
 Y N Diabetes _____
 Y N Heart Disease _____
 Y N Hypertension _____
 Y N Infertility _____

Y N Liver Disease _____
 Y N Neurologic Disorder _____
 Y N Renal Disease _____
 Y N Rh Sensitization _____
 Y N Thyroid Disorder _____
 Y N Trauma History _____
 Y N Uterine Abnormalities _____
 Y N Varicosities/DVT _____
 Y N Anesthetic Complications _____
 Y N Allergic Rhinitis _____
 Y N Other Family History _____
 Y N Other _____

Y N Previous Surgery/Hospitalization Year: _____ Type: _____
 Y N Previous Surgery/Hospitalization Year: _____ Type: _____
 Y N Previous Surgery/Hospitalization Year: _____ Type: _____

Y N Tobacco use Amt/day before preg _____ Amt/day during preg _____ #years of use _____
 Y N Alcohol use Amt/day before preg _____ Amt/day during preg _____ #years of use _____
 Y N Illicit/rec drugs Amt/day before preg _____ Amt/day during preg _____ #years of use _____

Patient Name: _____

Today's Date: ____/____/____

Genetic/Exposure History

Comments

- Y N Patient age ≥ 35 years on due date _____
- Y N Neural Tube Defect (Spina Bifida, Anencephaly) _____
- Y N Trisomy 21 (Down's Syndrome) _____
- Y N Congenital Heart Defect _____
- Y N Cystic Fibrosis _____
- Y N Tay-Sachs (Jewish, Cajun, French Canadian) _____
- Y N Thalassemia (Italian, Greek, Mediterranean, Asian) _____
- Y N Canavan Syndrome _____
- Y N Hemophilia or Hematologic Disease _____
- Y N Huntington's Chorea _____
- Y N Autism _____
- Y N If Autism, was person tested for Fragile X? _____
- Y N Mental Retardation _____
- Y N If yes, was person tested for Fragile X? _____
- Y N Muscular Dystrophy _____
- Y N Sickle Cell Disease or Trait (African) _____
- Y N Other Inherited Genetic or Chromosomal Disorder _____
- Y N Maternal metabolic Disorder (Type 1 Diabetes, PKU) _____
- Y N Recurrent Pregnancy Loss, or a Stillbirth _____
- Y N Other Birth Defects _____
- Y N Other Genetic Screening Issues _____
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- Y N Partner has history of HIV _____
- Y N Patient or Partner has history of Genital Herpes _____
- Y N Exposure to TB _____
- Y N Rash or Viral Illness since last menstrual period _____
- Y N History of Sexually Transmitted Disease _____
- Y N Possible Varicella Susceptibility (No previous chicken pox) _____
- Y N Other Exposure or History of Infections _____

Any other pertinent medical information we need to be aware of?
