



Asheville Obstetrics & Gynecology

Pregnancy History

Today's Date _____

We are happy to welcome you to our office. Please carefully read and answer these questions about your health so we can provide the best care for you and your baby. Everything is confidential.

Name _____ Age _____ Date of Birth _____

List allergies to medication, food or latex _____

What was the First day of last period? _____

Are you sure about this date? _____

When was your positive pregnancy test? _____

Were you planning this pregnancy? _____

If not, what method of birth control were you using? _____

When did you stop using birth control? _____

List any medications, prescription or not, since your last period _____

How many times, including this time, have you been pregnant? _____

How many full term, 37 weeks or more, deliveries have you had? _____

How many preterm, less than 37 weeks, have you had? _____

Have you had any miscarriages? _____ If so, how many? _____

Have you had any elective abortions? _____ If so, how many? _____

Have you had any tubal (ectopic) pregnancies? _____ If so, how many? _____

Please answer the following questions about your pregnancies:

	Date Of Birth	Weeks Pregnant At Delivery	Vaginal Or C/S	Boy Or Girl	Baby's Weight	Vacuum Or Forceps?	Doctor	Hospital
1								
2								
3								
4								

Medical History: Please circle if applies and state who beside details. Example: Mother, Father, Sister or Brother.

Diabetes: Patient Family Details _____

Hypertension: Patient Family Details _____

Heart Disease: Patient Family Details _____

Cancer: Patient Family Details _____

Seizure Disorder: Patient Family Details _____

Stroke: Patient Family Details _____

Thyroid Dysfunction: Patient Family Details _____

Psychiatric (medication, hospitalized, or treatment):

 Patient Family Details _____

Asthma: Patient Family Details _____

Anemia: Patient Family Details _____

Patient Only: Last Pap Smear, Date? _____

Circle all that apply below:

Abnormal Pap Blood Transfusion Mitral Valve Prolapse Heart Murmur
Chicken Pox Surgery STD's MRSA

Medications:

Social History:

Occupation _____

Marital Status: Single / Married / Divorced / Separated / Single living with Partner

Husband/Father of Baby _____ Phone _____

Occupation _____

How much do you Smoke? _____ # of packs per day: _____ How many years? _____

How much alcohol do you drink? _____ How many drinks a day? _____

What street drugs do you use? _____ What kind? _____ How often? _____

Do you have a cat? _____ If so, don't handle the litter box while pregnant.

What is your racial background? _____ Husband/Father of baby _____

Do any relatives of yours OR father of the baby's relatives have any of the following?

Birth Defect: No Yes Who & What _____

Cystic Fibrosis: No Yes Who & What _____

Down Syndrome: No Yes Who & What _____

Mental Retardation: No Yes Who & What _____

Sickle Cell Anemia: No Yes Who & What _____

Tay Sach's Disease: No Yes Who & What _____

Genetic/Inherited Diseases: No Yes Who & What _____