Date _____

Name _____
Last First Middle

LMP: _____ **EDC:** _____ **Drug Allergies** _____
(FIRST DAY OF LAST PERIOD) (OFFICE WILL FILL IN)

Birth Date	Age	Race	Marital Status S M W D SEP	Religion	Address	Phone Number

Father of Baby & Phone Number	Emergency Contact & Phone Number	Patient's Occupation & Type of Work	Highest Level of Education

OBSTETRICAL HISTORY

Total Pregnancies (INCLUDE CURRENT)	Full Term	Premature	Induced Abortion	Spontaneous Abortion (MISCARRIAGE)	Multiple Births	Living Children

PAST SIX PREGNANCIES

Delivery Date	Gest. Weeks	Birth Weight	Type of Delivery	Sex M/F	Anesthesia Yes/No	Comments/Complications	Length of Labor	Place of Delivery	Preterm Labor Yes/No

PAST MEDICAL HISTORY

	Yes	No	Detail Positive Remarks -- Include Date & Treatment
Diabetes	_____	_____	
Thyroid problems	_____	_____	
Cancer	_____	_____	
Heart Disease	_____	_____	
Breast disease/mass	_____	_____	
Stroke	_____	_____	
Anemia	_____	_____	
Bladder or Kidney disease	_____	_____	
Depression	_____	_____	
Liver disease/Hepatitis	_____	_____	
Migraines	_____	_____	
Blood vessel clots	_____	_____	
Lung disease	_____	_____	
Tobacco	_____	_____	
Alcohol	_____	_____	
Illicit Drugs	_____	_____	
Surgeries & Hospitalizations	_____	_____	