Stanford HEALTH CARE

Obstetrics and Gynecology
5575 W. Las Positas Blvd Suite 330, Pleasanton • 1133 E. Stanley Blvd Suite 205, Livermore

Your name:_____ Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

MENSTRUAL HISTORY

First day of your Last Menstrual Period (LMP) :_____ Was it normal in duration? ☐ Yes ☐ No
Do you have monthly periods? ☐ Yes ☐ No If no, how often do you have a period:_____
At what age did you have your first period: _____

CURRENT PREGNANCY

What is your height:_____ What is your weight pre-pregnancy:_____
Were you using birth control prior to finding out you were pregnant? ☐ No ☐ Yes If yes, type:_____
Will you be 35 years or older at the time of delivery? ☐ No ☐ Yes
Do you consider this pregnancy to be high risk? ☐ No ☐ Yes If yes, why? _____
Did you conceive by IVF or ART procedures? ☐ No ☐ Yes
If yes, what procedure: _____
Have you used any hot tubs, saunas, or steam bath since you found out you were pregnant? ☐ No ☐ Yes
Baby's Father Name: _____ Ethnicity: _____
Do you have a pediatrician? ☐ No ☐ Yes If yes, who?_____
What medications have you taken since your last menstrual period: _____
_____
Do you desire sterilization at the time of delivery? ☐ No ☐ Yes
Are you enrolled or plan to enroll in WIC Prenatal Care Program? ☐ No ☐ Yes

PAST PREGNANCY HISTORY

TOTAL PREGNANCIES	FULL TERM	PREMATURE	ABORTIONS INDUCED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

PAST PREGNANCY (LAST SIX)

DATE M/D/Y	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	PLACE OF DELIVERY	COMPLICATIONS

Was any pregnancy a second or third trimester loss? ☐ No ☐ Yes
Did you deliver any pregnancy prior to 37 week's gestation? ☐ No ☐ Yes
Did you have an incompetent cervix with any pregnancy? ☐ No ☐ Yes
Did you have high blood pressure or pre-eclampsia with any pregnancy? ☐ No ☐ Yes

Did you have gestational diabetes with any pregnancy? ☐ No ☐ Yes
Was any pregnancy delivered by C-section? ☐ No ☐ Yes
Are you Rh Negative? ☐ No ☐ Yes ☐ Unsure

MEDICAL HISTORY *(CHECK ALL THAT APPLY)*

☐ DIABETES	☐ HYPERTENSION	☐ D (RH) SENSITIZED
☐ AUTOIMMUNE DISORDER	☐ HEART DISEASE	☐ TUBERCULOSIS
☐ KIDNEY DISEASE	☐ THYROID DYSFUNCTION	☐ DRUG ALLERGIES
☐ NEUROLOGIC/EPILEPSY	☐ ASTHMA	☐ LATEX ALLERGY
☐ PSYCHIATRIC	☐ ANXIETY	☐ BREAST IMPLANTS
☐ DEPRESSION	☐ POST PARTUM DEPRESSION	☐ GYN SURGERY
☐ HEPATITIS	☐ LIVER DISEASE	☐ HISTORY OF ABNORMAL PAP
☐ VARICOSITIES	☐ PHLEBITIS	☐ UTERINE ANOMALY
☐ SEASONAL ALLERGIES	☐ ANESTHETIC COMPLICATIONS	☐ INFERTILITY
☐ HISTORY OF BLOOD TRANSFUSIONS		☐ ART TREATMENT

OTHER NOT LISTED ABOVE: _____

SURGICAL HISTORY

SURGERY PERFORMED	MONTH/YEAR	SURGERY PERFORMED	MONTH/YEAR
☐ ABDOMINAL SUGERY		☐ MYOMECTOMY	
☐ APPENDECTOMY		☐ LAPORSCOPY	
☐ C-SECTION		☐ LEEP/CONE BIOPSY	
☐ GASTRIC BYPASS		☐ OTHER:	
☐ OTHER:		☐	

DRUG ALLERGIES

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No

MEDICATION	REACTION	MEDICATION	REACTION

FAMILY HISTORY

Please write any diseases/conditions present in your family:

Mother: _____ ☐ Deceased

Father: _____ ☐ Deceased

Sister: _____ ☐ Deceased

Sister: _____ ☐ Deceased

Brother: _____ ☐ Deceased

Brother: _____ ☐ Deceased

Other family members (name relationship and medical disease/condition)

_____

GENETIC SCREENING

Do you, the baby's father, or a member of either family, been diagnosed with the any of the following:

NO		IF YES, WHO
☐	THALASSEMIA?	☐ _____
☐	NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANACEPHALY)?	☐ _____
☐	CONGENITAL HEART DEFECT?	☐ _____
☐	DOWN SYNDROME?	☐ _____
☐	TAY-SACHS	☐ _____
☐	CANAVAN DISEASE?	☐ _____
☐	FAMILIAL DYSAUTONOMIA?	☐ _____
☐	SICKLE CELL DISEASE OR TRAIT?	☐ _____
☐	HEMOPHILIA OR OTHER BLOOD DISORDERS?	☐ _____
☐	MUSCULAR DYSTROPHY?	☐ _____
☐	CYSTIC FIBROSIS?	☐ _____
☐	HUNTINGTON'S CHOREA?	☐ _____
☐	MENTAL RETARDATION / AUTISM?	☐ _____
☐	FRAGILE X	☐ _____
☐	OTHER INHERITED GENETIC OR CHOROMOSOMAL DISORDER?	☐ _____
☐	OTHER BIRTH DEFECT NOT LISTED ABOVE?	☐ _____

INFECTION HISTORY

	YES	NO
DO YOU LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB?		
DOES YOUR PARTNER HAVE A HISTORY? OF GENITAL HERPES		
HAVE YOU HAD A RASH OR VIRAL ILLNESS SINCE YOUR LAST PERIOD?		
HAVE YOU HAD THE CHICKEN POX OR THE VACCINATION?		

DO YOU HAVE A	YES	NO
HISTORY OF HEPATITIS B OR C?		
HISTORY OF HPV?		
HISTORY OF HIV?		
HISTORY OF STI?		
HISTORY OF GENITAL HERPES?		
HISTORY OF GONORRHEA?		
HISTORY OF CHLAMYDIA?		
HISTORY OF SYPHILIS?		

SOCIAL HISTORY

Do you use Tobacco? ☐ Never ☐ Current ☐ Former Use smokeless tobacco?: ☐ No ☐ Yes

Pack of cigarettes each day _____ Number of years smoked? _____

Have you smoked since finding out you were pregnant? ☐ No ☐ Yes

Is there passive smoke exposure? ☐ No ☐ Yes

Do you drink Alcohol? ☐ Never ☐ Daily ☐ Socially Drinks per week_____

Have you drank alcohol since finding out you were pregnant? ☐ No ☐ Yes

Do you use Recreational Drugs? ☐ No ☐ Yes

If yes, which type? ☐ Methamphetamine ☐ Ecstasy ☐ Heroin ☐ Cocaine IV ☐ Prescription Drugs

Have you used recreational drugs since finding out you were pregnant? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes How often _____days/week for how long: _____

What type of exercise: _____

Are there cats in the home? ☐ No ☐ Yes If yes, who changes the little box? _____

Have you ever been a victim of physical abuse or domestic violence? ☐ No ☐ Yes

Do you wear your seatbelt frequently? ☐ No ☐ Yes

Are there firearms in the home? ☐ No ☐ Yes?

Are there smoke detectors in the home? ☐ No ☐ Yes

Are there carbon monoxide detectors in the home? ☐ No ☐ Yes

----------Clinic Use Only----------

Weight _____ MD order ☐ PN Labs

Blood Pressure _____/_____

U/S EDD _____

EDD by LMP _____