NEW / ESTAB

Arrowhead Women's Center Obstetrical Information

Name: _____ Date of Birth: _____

Occupation: _____ Marital Status: _____ Racial background: _____

Baby's Father's Name: _____ Fathers Age: _____ Father's Race:_____

Father's Occupation: _____ Date of last menstrual period: _____

Do you or the baby's father have any family history of genetic disorders or birth defects (Cystic Fibrosis, Down's Syndrome, mental retardation, Muscular Dystrophy, etc.)? ☐ Yes ☐ No If yes, what type of disorder, and how are they related to you?

_____

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please answer the following:

Are you or the baby's father African-American? ☐ Yes ☐ No If yes, have you had Sickle Cell Screening? ☐ Yes ☐ No

Are you or the baby's father of Jewish ancestry? ☐ Yes ☐ No If yes, have you had Tay-Sach's screening tests? ☐ Yes ☐ No

PREGNANCY HISTORY

List any and all pregnancies you have had including miscarriages, abortions, stillbirths, etc., and the type of delivery if possible.

Pregnancy Number	Date	Weeks	Sex and birth weight of baby	Delivery Mode (vaginal or C-section)	Obstetrical Problems	Neonatal Problems	Notes

Do you have any cats at home? ☐ Yes ☐ No Have you had the chicken pox? ☐ Yes ☐ No If no, did you have the vaccine? ☐ Yes ☐ No

Did you get pregnant on birth control? ☐ Yes ☐ No If yes, what type?_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, why?_____

Do you have any chronic health conditions or medical history that we should be aware of? _____

_____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how much? _____

Do you use tobacco? ☐ Yes ☐ No If yes, what type and how much per day?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____ Date of last use:_____

Do you use drugs? ☐ Yes ☐ No If yes, what type and when did you last use it?_____

Do you have any known drug allergies? _____

List any medications that you have taken since you last period:_____

_____

List any surgeries that you have had: _____

_____

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No If yes, what and when? _____

When was your last pap smear? _____ Have you ever had an abnormal pap? _____