Chrysalis
Obstetrics & Gynaecology

Your name:

Your spouse's/partner's name:

Date of appointment:

Congratulations on your pregnancy! Please fill out the form below:

OBSTETRICAL HISTORY: First day of the last menstrual period (YYMMDD):_____

Total number of:

Pregnancies: _____Children: _____Miscarriages: _____Abortions: _____Ectopics: _____

YYMMDD	Hospital	Gest Age	Hours In Labour	Delivery Type (Normal, Vacuum, Forceps, Cesarean)	Complications	Sex	Weight

Medical History: (please circle appropriate answer/ if yes please specify):

Asthma	No	Yes _____
Autoimmune (eg. Lupus)	No	Yes_____
Bleeding/Clotting Problems	No	Yes_____
Heart problems	No	Yes_____
High Blood Pressure	No	Yes_____
Diabetes	No	Yes_____
Thyroid	No	Yes_____
GI (bowel) problems	No	Yes_____
Epilepsy	No	Yes_____
Kidney problems	No	Yes_____
Hepatitis/liver disease	No	Yes_____
HIV/AIDS	No	Yes_____
Chlamydia/Gonorrhea/Herpes/Warts	No	Yes_____
Tuberculosis (Tb)	No	Yes_____
Chicken Pox or Vaccine	No	Yes_____
Psychiatric (Depression/anxiety)	No	Yes_____
Assisted conception (Clomid/IVF)	No	Yes_____
Anesthetic problems	No	Yes_____
Blood transfusions	No	Yes_____
Operations	No	Yes_____
Other	No	Yes_____
Allergies	No	Yes_____
Height		_____

Medications: Please list your medications below, including prenatal vitamins:

Life Style History/Social History: (if yes, please specify how much/how long/etc)

Do you smoke?	No	Yes_____Quit (YYMMDD)_____
Alcohol use in pregnancy?	No	Yes_____
Drug use?	No	Yes_____Quit (YYMMDD)_____
Do you work?	No	Yes (please specify type of work)_____

Family History: (please specify who in the family is affected)

Diabetes	No	Yes_____
Heart problems	No	Yes_____
High Blood Pressure	No	Yes_____
Malformation/Birth Defects	No	Yes_____
Mental Illness/Depression	No	Yes_____
Twins/multiple pregnancy	No	Yes_____
Spouse / partner a blood relative? (eg. First/second cousins)	No	Yes_____
Other	No	Yes_____