



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 _____