Perinatal History Form

Name: ____ DOB: ____/____ /___________
Last First
Referred By:__________________________________Married: Yes [ ] No [ ] Age: _____ yrs
Occupation: ____ Ethnic Origin: W AA HISP ASIAN OTH
Reason: ____ Pregnancy: SP IVF OI/IUI
Date of Visit: _____/____/_______ Obstetrician : _______________________________________
Allergies: ____ **LMP:** ___/___/______

Patient Habits and Medication History:

Special Diet: Yes { } No { } Specify: ____
Tobacco Use: Yes { } No { } If a past smoker, last year she smoked:_________________
Alcohol Use: Yes { } No { } If yes, how many drinks per week on average?___________
Illicit drugs: Yes { } No { } ____
Medications/Supplements: Yes { } No { } List below all that apply:name, frequency, dose
1) ____
2) ____
3) ____
4) ____

Patient Medical History:

Diabetes:	Yes { } No { } ____________________________
Hypertension:	Yes { } No { } ____________________________
Kidney Disease:	Yes { } No { } ____________________________
Heart Disease:	Yes { } No { } ____________________________
Lung Disease:	Yes { } No { } ____________________________
Vein problem:	Yes { } No { } ____________________________
Gastrointestinal:	Yes { } No { } ____________________________
Autoimmune:	Yes { } No { } ____________________________
Clotting Prob.:	Yes { } No { } ____________________________
Hepatitis:	Yes { } No { } ____________________________
Tuberculosis:	Yes { } No { } ____________________________
Stress Dep/sion:	Yes { } No { } ____________________________
Other:	Yes { } No { } ____________________________

Patient Surgical History:

Cesarean Sect:	Yes { } No { } ____________________________
Myomectomy:	Yes { } No { } ____________________________
D&C:	Yes { } No { } ____________________________
Cone/ LEEP:	Yes { } No { } ____________________________
Laparoscopy:	Yes { } No { } ____________________________
Appendectomy:	Yes { } No { } ____________________________
Gallbladder:	Yes { } No { } ____________________________
Tonsillectomy:	Yes { } No { } ____________________________
Ovarian Cyst:	Yes { } No { } ____________________________
Intestinal:	Yes { } No { } ____________________________
Kidney:	Yes { } No { } ____________________________
Other:	Yes { } No { } ____________________________

Family History:

Diabetes:	Yes { } No { } ______
Hypertension:	Yes { } No { } ______
Kidney Disease:	Yes { } No { } ______
Heart Disease:	Yes { } No { } ______
Lung Disease:	Yes { } No { } ______
Mental Retard:	Yes { } No { } ______
Stroke:	Yes { } No { } ______
DVT:	Yes { } No { } ______
Ovarian Cancer:	Yes { } No { } ______
Colon Cancer:	Yes { } No { } ______
Tuberculosis:	Yes { } No { } ______
Premat. Death:	Yes { } No { } ______
Other:	Yes { } No { } ______

Obstetrical History (Only for previous pregnancies) **G:_____ P:_____ A:______ Living:_______**

IUGR:	Yes { } No { }______
Pregnancy loss <12wks:	Yes { } No { }______
Pregnancy loss 12-24 wks:	Yes { } No { }______
Pre-eclampsia:	Yes { } No { }______
Diabetes:	Yes { } No { }______
Late fetal death >24 wks:	Yes { } No { }______
Preterm Birth:	Yes { } No { }______
PROM:	Yes { } No { }______
Bleeding:	Yes { } No { }______
Fetal abnormalities:	Yes { } No { }______
Abruption:	Yes { } No { }______
Cerclage:	Yes { } No { }______
Other:	Yes { } No { }

List all pregnancies here (year, GA at delivery, delivery mode, birth weight, gender, outcome):

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Gynecologic History:

Endometriosis:	Yes { } No { }______
Leiomyomas:	Yes { } No { }______
Ovarian Cysts:	Yes { } No { }______
Ectopic Pregnancy:	Yes { } No { }______
D&E procedure:	Yes { } No { }______
PCOS:	Yes { } No { }______
Pelvic Infection:	Yes { } No { }______
Uterine Anomalies:	Yes { } No { }

Physical / vital signs, review of Systems, risk factors and impression: (For office staff use only)

Wt:______ lb. Ht: _______ BP: ______/_____ mmHg P: ______ bpm Temp:______ ^{0}F

Review of systems:

General appearance: Eutrophic____Hypertrophic____ Obese____Hypotrophic____

Head & Neck: WNL: Yes { } No { }________________________________

Breast: WNL: Yes { } No { }________________________________

Cardiac: WNL : Yes { } No { }________________________________

Respiratory: WNL: Yes { } No { }________________________________

Renal: WNL: Yes { } No { }________________________________

Gastrointestinal: WNL Yes { } No { }________________________________

Neurological: WNL Yes { } No { }________________________________

Psychiatric: WNL Yes { } No { }________________________________

Peripheral Vascul:WNL Yes { } No { }________________________________

Past & present Pregnancy Related Risk Factors: Check all that apply. Comment as necessary.

Risk factor	Response
Preterm Labor:	Yes { } No { } ________________________
Incompetent cervix:	Yes { } No { } ________________________
Growth Failure (IUGR):	Yes { } No { } ________________________
Pre-eclampsia:	Yes { } No { } ________________________
Diabetes:	Yes { } No { } ________________________
Abruption:	Yes { } No { } ________________________
Fetal anomaly:	Yes { } No { } ________________________
Placenta Thrombosis:	Yes { } No { } ________________________
Unilateral Placenta:	Yes { } No { } ________________________
Fetal Demise:	Yes { } No { } ________________________
PROM:	Yes { } No { } ________________________
Recurrent Fetal Loss:	Yes { } No { } ________________________
Previa:	Yes { } No { } ________________________
Maternal Cardiac:	Yes { } No { } ________________________
Maternal Renal:	Yes { } No { }

Impression:

1) Thrombosis Disorder: Genetic { }, Acquired { }, Familial { }________________________
2) Multiple gestation: Twin { }, Triplet { }, Quads { }Higher order { } __________________
3) Chronic hypertension/Preeclampsia: ________________________________
4) Diabetes: Gestational { }, Pregestational { }, Class: B { },C{ }, D { },R { }, F { }________
5) Preterm Labor:________________________________
6) Incompetent Cervix: ________________________________
7) ART Pregnancy: OI/IUI { }, IVF { }, IVF-D { }________________________________
8) Recurrent Pregnancy loss: ________________________________
9) Missed Abortion: First Trimester { }, Second Trimester { }____________________________
10) Other, Specify:

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Attending Signature