

Obstetrical Record

Patient _____ **Date of Birth** _____ **Age** _____
Language: _____ **Occupation:** _____ **Education** _____
Obstetrician: _____ **Pediatrician:** _____

Pregnancy History

Total Pregnancies _____ Born Alive _____ Multi. Gestations _____ Term _____ Preterm _____ Parity _____
 Living _____ Ectopics _____ Ab. Spontaneous _____ Ab. Induced _____

Menstrual History

LMP Date is ___ approximate ___ definite ___ unknown LMP normal ___ yes ___ no LMP regular ___ yes ___ no
 Interval Days _____ Duration _____ Menarche _____ (age at onset) Date of LMP _____
 Contraceptive Type _____ Contraceptive discontinued (date) _____ Pregnancy planned ___ yes ___ no

Past Pregnancies

Delivery Date (mm/dd/yr)	Gestational Age (weeks)	Route of Delivery	Weight (lb/oz)	Sex	Comment

Medical History				Allergies				
	No	Yes	Comment		No	Yes	Comment	
Diabetes				Drug Allergy/Sensitivity				
Hypertension				Environmental Allergies				
Heart Disease				Food Allergies				
Autoimmune Disorder				Latex				
Kidney Disease/UTI				Transfusion Reaction				
Neurologic/Epilepsy				Anesthesia Problems				
Psychiatric				Seasonal Allergies				
Depression/Postpartum				Screening Items				
Hepatitis/Liver Disease					Y/N	Relative	Age	Living Y/N
Varicosities/Phlebitis				Alpha Thalassemia				
Thyroid Dysfunction				Beta thalassemia				
Trauma/Violence				Cystic Fibrosis				
History Blood Transfusion				Hemophilia				
D (Rh) Sensitized				Huntingtons Chorea				
Pulmonary (TB, Asthma)				Mental Retardation				
Breast				Muscular Dystrophy				
Gyn Surgery				Neural Tube Defect				
Operations/Hospitalizations				Trisomy (Down's Syndrome)				
History of Abnormal Pap				Radiation Exposure				
Uterine Anomaly				Sickle Cell				
Infertility				Tay Sachs Disease				
Relevant Family History								
Tobacco			Amt/day					
Alcohol			Amt/day					
Illicit/Recreational Drugs			Amt/day					

Patient Signature: _____ Interviewer's Signature: _____