

Antepartum Record

Physicians for Women, P.C.

Name: _____ Date of Birth: _____ Age: _____
 Phone: _____ First Day of Your Last Period: _____

YOUR PREGNANCY HISTORY:

A pregnancy is 40 weeks if it continued until your due date. Please list all pregnancies, including miscarriages or abortions, in order.

Date of birth, miscarriage or abortion	Weeks at time of birth, miscarriage or abortion	Length (Hours) of labor	Birth weight & Sex	Type of birth- vaginal, Cesarean, forceps, Vacuum	Anesthesia: Epidural, spinal, general, None	Comments/complications/practitioner delivering baby or providing care

If you answer yes to any of the remaining questions, please note the number of the problem on the comment line, and the details, such as when diagnosed, medications needed, etc.

YOUR MEDICAL HISTORY: Have *you* ever had any of the following problems?

	Yes	No		Yes	No
1. Diabetes			13. Asthma		
2. High blood pressure			14. Medication allergies		
3. Heart or heart valve problems			15. Any previous surgeries		
4. Digestive problems, including gastric bypass, lap band procedures			16. Anesthesia complications		
5. Kidney problems or bladder/ urinary tract infections			17. Any previous hospitalizations		
6. Neurologic problems such as migraines, seizures or epilepsy			18. Abnormal pap smears Date of last pap smear _____		
7. Psychiatric problems such as bipolar disorder or depression			19. Uterine abnormalities		
8. Hepatitis or liver problems			20. Difficulty getting pregnant		
9. Varicose veins or blood clots in your legs or elsewhere			21. Infertility treatments		
10. Thyroid problems			22. Did your mom take a medication called DES during her pregnancy with you?		
11. A major accident with a head injury or broken bones			23. Other medical problems		
12. History of a blood transfusion			24. Do you know your blood type?		

Comments: _____

FAMILY GENETIC HISTORY:

Name: _____

This includes *you, the baby's father, or anyone else in either family:*

	Yes	No		Yes	No
1. Your age is 35 years or greater			9. Cystic fibrosis		
2. Thalassemia (Severe anemia common with Italian, Greek, Mediterranean or Oriental background):			10. Huntington chorea		
3. Neural tubal defect (spina bifida, spinal cord or brain development problems)			11. Mental retardation, not due to a birth problem or infection		
4. Down syndrome			12. Other inherited genetic or chromosomal disorder		
5. Tay-sachs (Jewish background)			13. You or your baby's father had a child with a birth defect not listed above		
6. Sickle cell disease or trait			14. More than 3 first trimester miscarriages		
7. Hemophilia (blood clotting disorder in males, inherited through females in family)			15. Medications or street drugs, including marijuana since your last period		
8. Muscular dystrophy			16. Other significant family history		

Comments: _____

Do you feel safe in your home environment? _____

INFECTION HISTORY:

Have you or your partner **ever** been exposed to or tested positive for any of the following?

	Yes	No		Yes	No
24. HIV			28. Rash or viral illness since last menstrual period		
25. Hepatitis			29. History of a sexually transmitted infection, such as genital herpes, chlamydia, gonorrhea, HPV, syphilis		
26. Tuberculosis			30. Have you ever had chicken pox?		
27. Genital herpes			31. A positive test for MRSA		

Comments: _____

When was your last TDaP (tetanus, diphtheria, & acellular pertussis) vaccination? _____

Do you smoke? Yes No How much per day? _____ When did you quit? _____

Did you drink any alcohol during the pregnancy? Yes No How much? _____

Have you used any street drugs during the pregnancy? Yes No What? _____

THE ABOVE INFORMATION IS CORRECT. I HAVE TAKEN TIME TO PREVIOUSLY INVESTIGATE MY PERSONAL AND FAMILY MEDICAL HISTORY SO AS TO ENSURE ACCURATE RESPONSES TO THE ABOVE.

Patient or Responsible Party Signature

Date

Practitioner Reviewed: _____