New Pregnancy

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Date:_____ Chart #:_____
Patient Name:_____ Date of Birth:_____
Address:_____ Age:_____
City/State/Zip:_____ Primary Language: _____
Telephone Number:_____ OB Physician:_____
Primary Care Physician:_____ Chosen Pediatrician:_____
Insurance Coverage:_____
Preferred Pharmacy and Location:_____

Have you been seen here for pregnancy before? Yes No
Including your current pregnancy, how many pregnancies have you had? _____
How many live births have you had? _____
Any miscarriages? Yes No How many?_____ What year?_____
Any elective abortions? Yes No How many?_____ What year?_____
Any ectopic pregnancies? Yes No How many?_____ What year?_____
Any stillbirths? Yes No How many?_____ What year?_____
If yes, what was the cause of the stillbirth? _____
Any children born with birth defects? Yes No
If yes, please specify:_____

What was the first day of your last period? _____
How old were you when you had your first period? _____
How often are your periods? _____
How many days do your period last? _____
Are your periods: Heavy Light Regular

What were you using for birth control (please circle all that apply)?

Abstinence	Condoms	Foam	IUD – Paragard	Tubal Coils
Barrier	Contraceptive Patch	Hysterectomy	Natural Family Planning	Vaginal Ring
Bilateral Tubal	Depo Provera	Nexplanon	Rhythm	Vasectomy
Birth Control Pills	Diaphragm	IUD – Mirena	IUD – Skyla	Withdrawal

If you were taking Birth Control Pills, what brand were you taking?_____
When did you stop using birth control?_____

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Bakersfield, California 93311
(661) 663-4800 Phone
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Are you allergic to any medications? Yes No

If yes, please list the medications and your reaction:

Medication	Reaction

Are you currently taking any medications? Yes No

If yes, please list the medications and their dosage:

Medication	Dose	Treatment for

When was your last pap smear? _____ Results were: Normal Abnormal

Pregnancy History

Day / Month / Year	Was Pregnancy		Was Delivery (please list gestation wks)		Delivering Physician	Delivery Vaginal or C-Section	Sex of Child	Birth Weight	**Complications
	Miscarriage	Elective Abortion	Full Term	Pre Term					
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No
	Y N	Y N				V C			Yes No

** If you noted “Yes” to Complications, please specify year and type of event (i.e., miscarriage, ectopic, elective abortion)

_____

_____

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Medical History

Please mark any medical conditions you have been or are currently being treated for:

Condition		Condition		Condition	
Acid Reflux	☐	AIDS	☐	Anemia	☐
Asthmas	☐	Bi-Polar Disorder	☐	Cancer	☐
Cervical Dysplasia	☐	Coagulation Disorders	☐	Depression / Post-Partum Depression	☐
Diabetes	☐	Endometriosis	☐	Fibroids	☐
Headaches	☐	Heart Defects	☐	Heart Murmur	☐
Hepatitis	☐	Hypertension	☐	Hyperthyroidism	☐
Hypothyroidism	☐	Infertility	☐	Kidney Disease / Stones or Infections	☐
Lupus	☐	Seizure Disorders / Epilepsy	☐	Sickle-Cell Disease	☐
Sickle-Cell Trait	☐	Tuberculosis	☐	Uterine Anomalies	☐

Diabetic Risk Assessment

Please check if present

- ☐ Type 1 Diabetes (Insulin)
- ☐ Type 2 Diabetes (Oral Hypoglycemic)
- ☐ Type 2 Diabetes (Insulin)

****If one or more of the following risks are present, a 50gm Glucola test will be recommended by your physician

- ☐ Previous Gestational Diabetes
- ☐ Family history of diabetes (Parents, Grandparents, Siblings, Children)
- ☐ Unexplained Still Birth
- ☐ Previous births with congenital anomalies
- ☐ Previous infant birth weight greater than 8lbs, 13oz.
- ☐ Prior history or current diagnosis of Polyhydramnios
- ☐ Prior history or current diagnosis of PIH, Toxemia, or Preeclampsia
- ☐ Maternal age at delivery will be 35 years or older
- ☐ Maternal weight greater than 20% BMI (see chart on the right)

BMI Chart

Height	Weight
4' 9"	127
4' 10"	131
4' 11"	134
5' 0"	138
5' 1"	142
5' 2"	146
5' 3"	151
5' 4"	157
5' 5"	162
5' 6"	167
5' 7"	172
5' 8"	176
5' 9"	181
5' 10"	186
5' 11"	191

Past Surgical History

Please list any and all of your surgeries:

Year	Type of Surgery	Reason for Surgery

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Social History

Do you currently use illicit drugs? Yes No If yes, please list: _____

Do you have a history of drug abuse? Yes No If yes, please list: _____

Do you drink? Yes No If yes, how often? _____ How many per day? _____

Are you currently sexually active? Yes No

What is your marital status? Single Married Living with Partner Separated Divorced

What is your ethnicity? (please circle)

African American Hispanic Asian / Filipino American Indian (or Alaskan Native)

Native Hawaiian / Pacific Islander Unknown Other: _____

What is your occupation? _____

In your occupation, are you potentially exposed to infectious diseases or hazardous materials? Yes No

If yes, please list all materials you are potentially exposed to: (i.e. radiation, biohazards, chemicals) _____

Do you smoke? Yes No If yes, how many per day? _____

Do you use caffeine? Yes No

Do you exercise? Yes No If yes, do you exercise (please circle) Daily Weekly Seldom

Family History

Please list family members' medical conditions (please include parents and siblings)

**Do NOT include in-laws or adopted parents or siblings.

**Be sure to list <u>any</u> immediate family members with any history of breast, cervical, ovarian, uterine, or colon cancer.

Relative Type (Father, Mother, Siblings)	Living / Deceased	If deceased, age at death	Illnesses / Disorders

What is your height?_____ What is your weight prior to pregnancy?_____

Genetic History

Please note any conditions that pertain to yourself or immediate family members.

<u>Condition</u>	<u>Please Circle Yes or No</u>	
Thalassemia	Yes	No
Neural Tubal Defects	Yes	No

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Genetic History (continued)

Downs Syndrome	Yes	No
Tay-Sachs	Yes	No
Canavan / Leukodystrophy	Yes	No
Sickle-Cell	Yes	No
Hemophilia	Yes	No
Muscular Dystrophy	Yes	No
Cystic Fibrosis	Yes	No
Huntington's Chorea	Yes	No
Mental Retardation / Autism	Yes	No
Unspecified Chromosomal Disorders	Yes	No
Maternal Metabolic Disorders	Yes	No
Unspecified Birth Defects	Yes	No

Other:_____

_____

Personal Infection History

Please note any conditions that pertain to you.

Diseases	Please Circle Yes or No		Years or Age of Onset
AIDS	Yes	No	_____
Chlamydia	Yes	No	_____
Gonorrhea	Yes	No	_____
Hepatitis	Yes	No	_____
HIV	Yes	No	_____
HPV (Human Papilloma Virus / Genital Warts)	Yes	No	_____
HSV (Genital Herpes or Oral Herpes)	Yes	No	_____
Syphilis	Yes	No	_____
Trichomonas	Yes	No	_____
Diptheria	Yes	No	_____
Mumps	Yes	No	_____
Pertussis (Whooping Cough)	Yes	No	_____
Polio	Yes	No	_____
Rubella (Measles)	Yes	No	_____
Tuberculosis	Yes	No	_____
Tetanus	Yes	No	_____
Varicella (Chicken Pox)	Yes	No	_____