OBSTETRICAL MEDICAL AND FAMILY HISTORY

Name:_____Date:_____

Birthdate:_____Age:_____Race:_____

Marital Status: S M W D Sep Language:_____

Occupation:_____Education:_____

Father of Baby:_____Phone:_____

Total number of pregnancies:

Full-term births		Premature births		Induced abortions		Multiple births	
Spontaneous miscarriages		Ectopic (tubal) pregnancies		Number of living children		**Notes:**	

Menstrual History

1st day of last menstrual period:_____Certain: Yes No

Was this a normal period: Yes No Are periods monthly: Yes No

Interval of Periods (1st day of one to the 1st day of the next) _____days

Age menstrual periods began:_____

Were you using birth control when you became pregnant: Yes No

Was this a planned pregnancy: Yes No

Date of Pregnancy test:_____ blood_____ urine_____

Past Pregnancies (Last 6)

DATE MO/YR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANEST.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS