CAPITAL WOMEN'S CARE®
"Working Together for Women's Health"

NEW OB PATIENT INFORMATION

Provider: _____ *Date:* _____

Patient Name: _____ DOB: _____
Race/Ethnicity: _____ Marital Status: _____
Occupation: _____ Employer: _____

Partner Information
Name: _____ Age: _____
Race/Ethnicity: _____ Phone Number: _____
Occupation: _____ Employer: _____

Obstetric History: Please list ALL prior pregnancies, including miscarriages and terminations.

Date of Delivery	*Gestational Age at Delivery*	*Length of Labor*	*Weight of Baby*	*Type of Delivery (vaginal/ c-section)*	*Anesthesia (Y/N)*	*Preterm Labor (Y/N)*	*Sex of Baby (M/F)*	*Place of Delivery*

*In **PREVOUS** pregnancies have you experienced:*

- ☐ Active tuberculosis
- ☐ Amniotic fluid problem
- ☐ Blood clot
- ☐ Chromosomal anomalies/problems
- ☐ Fetal growth restriction
- ☐ Fetal or neonatal death
- ☐ Gestational diabetes
- ☐ Hemorrhage
- ☐ Incompetent cervix
- ☐ Neurological damaged infant
- ☐ Preeclampsia or High Blood Pressure

*In your **CURRENT** pregnancy have you experienced:*

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Fever
- ☐ Headache
- ☐ Nausea
- ☐ Rashes or viral illness since your last period
- ☐ Urinary complaints
- ☐ Vaginal bleeding
- ☐ Vaginal discharge/odor
- ☐ Vomiting
- ☐ Other: _____

Current Pregnancy:

List the current medications and vitamins you are taking: _____
Is this pregnancy your second pregnancy in 12 months? **Y / N**
Was any assistive technology used to achieve your current pregnancy? **Y / N** If so, what type? _____
Who is your fertility provider? _____

What products have you been exposed to since your last menstrual period?

- ☐ Caffeine
- ☐ Cats
- ☐ Over-the-counter medication
- ☐ Prescription medication
- ☐ Alcohol
- ☐ Chemical or radiation exposure
- ☐ Tobacco products
- ☐ IV drug use by you or your partner
- ☐ Illicit drugs
- ☐ Other: _____

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YOUR Medical History:

☐ Abnormal pap smear	☐ Breast problems	☐ Heart disease	☐ Mitral valve prolapse	☐ Tuberculosis
☐ Anxiety/Depression	☐ Breast surgery	☐ Hepatitis	☐ Reactions to anesthesia	☐ Uterine anomaly
☐ Asthma	☐ Diabetes	☐ Hospitalizations	☐ Rheumatic fever	☐ Uterine surgery
☐ Autoimmune disorder	☐ DES exposure	☐ Hypertension	☐ Seasonal allergies	☐ Varicosities/Phlebitis
☐ Blood transfusion	☐ Epilepsy	☐ Kidney Disease	☐ Sexually transmitted infections	☐ Other: _____ _____
☐ Bowel disease	☐ Genital herpes	☐ Liver Disease	☐ Thyroid dysfunction	_____ _____

Do you know your blood type? **Y / N** Are you Rh negative? **Y / N**
Do you have any diet restrictions or follow any special diets? _____
Do you exercise? How often? What type? _____
How often did you get a period prior to pregnancy? _____
When was the **FIRST** day of your last period? _____
When was your last pap smear? Was it normal? _____

FAMILY Medical History: Please check all that apply to the PATIENT'S family and note WHO has the specified disorder

☐ Major pregnancy complications _____	☐ High blood pressure _____
☐ Diabetes _____	☐ Cancer _____
☐ Preeclampsia _____	☐ Thyroid disease _____
☐ Other diseases or disorders relevant to your pregnancy _____	

Genetic History:
Have you or the father of your child had a child born with birth defects or have birth defects yourself? **Y / N**
Have you ever had genetic counseling and/or chromosomal studies? **Y / N**

*Have babies in **YOU** or your **PARTNER'S** family with any of the following:*

☐ Down syndrome _____	☐ Deformities _____
☐ Mental retardation_____	☐ Hemophilia _____
☐ Emotional problems _____	☐ Muscular dystrophy _____
☐ Birth defects _____	☐ Cystic fibrosis _____
☐ Neural tube defects _____	☐ Other: _____

*Some genetic problems may occur more frequently in couples with certain racial or ancestral background. Please **CIRCLE** all that apply to **YOU** or the **BABY'S FATHER:***

Jewish Ancestry / Black / Italian / Greek / Mediterranean / Philippino / Southeast Asian

Home Safety
Do you wear seatbelts? **Y / N**
Do you have working smoke detectors and carbon monoxide detectors in your home? **Y / N**
Do you have firearms in your home? **Y / N**

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