1919 Lathrop St. Suite 222
Fairbanks, AK 99701

OB History Form

Full Legal Name: _____ Today's Date: _____

Preferred Name: _____ Pronouns: _____ Date of Birth: _____

Race: _____ Marital Status: □ Married □ Single □ Other _____ Occupation: _____

Father of the Baby: _____

Emergency Contact: _____ Contact Number: _____

Menstrual History

1st day of your last menstrual period (LMP): _____

Are you sure about the date of your LMP: ☐ Yes ☐ No

Prior to becoming pregnant were your periods monthly: ☐ Yes ☐ No

Were you taking birth control when you became pregnant: ☐ Yes, Type: _____ ☐ No

When was your first positive pregnancy test: _____

Past Pregnancies

Total Pregnancies (Including Current)	Full Term	Premature (Before 37wks)	Elective Abortion	Miscarriage	Ectopic	Multiple Births	Living

Date Month/ Year	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Epidural	Place of Delivery	Preterm Labor Y/N	Comments/ Complications

Infection History

Living with someone with TB or exposed to TB	**YES** or **NO**	Hepatitis B or C	**YES** or **NO**
Personal history of genital Herpes	**YES** or **NO**	History of STD Type:	**YES** or **NO**
Partner history of genital Herpes	**YES** or **NO**	History of MRSA	**YES** or **NO**
Rash or viral illness since LMP	**YES** or **NO**	History of Chicken Pox	**YES** or **NO**

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Medical History

	Y or N		Y or N
Diabetes		Blood Type Rh Negative	
Hypertension		Pulmonary (TB, Asthma)	
Heart Disease		History of Preeclampsia	
Auto-Immune Disorder		Breast Issues	
Kidney Disease/UTI		GYN Surgery	
Psychiatric Illness/Depression/ Postpartum Depression		Operations/Hospitalizations **Year/Type:**	
Neurologic/Epilepsy		Anesthetic Complications	
Hepatitis/Liver Disease to include Cholestasis of Pregnancy		History of Abnormal Pap **Last pap:** **Where:**	
History of Blood Clot/Clotting Disorder		Uterine Anomaly/DES	
Thyroid Dysfunction		Infertility/Reproductive Treatments	
Trauma/Domestic Violence		**Other Family History:**	
History of Hemorrhage			
Tobacco		**Drug/Latex Allergies:**	
Illicit/Recreational Drugs			
Alcohol		**Current Medications (Including Vitamins):**	

If you have marked yes on any of the above conditions, please explain: _____

_____

Genetic Screening/History

Please include your history as well as baby's father (FOB) and other blood related family members

	Y or N		Y or N
Your age is 35yrs or older as of Estimated Due Date		Huntington's Chorea	
Thalassemia (Italian, Greek, Mediterranean or Asian background)		Mental Retardations/Autism	
Neural Tube Defect		Was this person tested for Fragile X?	
Congenital Heart Defect		Other inherited Genetic or Chromosomal Abnormality	
Down Syndrome		Maternal Metabolic Disorder (Diabetes, PKU, EG)	
Tay-Sachs, Canavan Disease, Familial Dysautonomis (Ashkenazi Jewish)		Patient or FOB had child with birth defects not listed	
Sickle Cell Disease or Trait (African)		Recurrent Pregnancy loss or stillbirth	
Hemophilia/Blood Disorders		Medications (including vitamins/supplements),	
Muscular Dystrophy		Illicit drugs/Alcohol since LMP	
Cystic Fibrosis/CF Carrier		**If so what type:**	