Antepartum Record

OBGYN Services, P.C

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Patient Name: _____ D.O.B: _____ Date: _____

Pharmacy/Town: _____Primary Language: _____ Pt Race: _____

Partner Name: _____ Race: _____ D.O.B_____

ALLERGIES: List medications you are allergic to and reaction (ie: hives, vomiting, difficulty breathing, etc)

_____

MEDICATIONS: List medications and supplements that you take- Please include the dose and how often you take it:

_____

_____

_____

_____

_____

LAST MENSTRUAL PERIOD: _____ Were you on birth control time of conception? Yes_____ No_____

If so, what form of contraception: _____

PAST MEDICAL/ SURGICAL HISTORY: write all that apply

_____

_____

_____

_____

SOCIAL HISTORY: Circle all that apply

Smoking: Never Current everyday (packs per day_____) Current some days Former (YR quit_____)

Alcohol Use: Never More than 10 drinks/week Less than 10 drinks/week Alcoholic

Substance Use: Never Cocaine Heroin Prescription Drugs Other Former use (what/when) _____

Sexual Activity with: Men Women Both Other_____

Domestic Violence/Abuse: Never Former Current

FAMILY MEDICAL HISTORY: (Please specify family member, ie mother, father, sister, brother, etc)

_____

_____

_____

_____

_____

OB/GYN–RELATED CANCER HISTORY: (Please specify family member & age of diagnosis)

Breast Cancer Ovarian Cancer Colon Cancer Uterine Cancer Other: _____

GYNECOLOGIC HISTORY:

_____

_____

_____

SCREENING TESTS: (when performed and what Doctor/facility)

Last Mammogram: _____ Last Colonoscopy: _____

Last PAP Smear: _____ Last Bone Density/DEXA Scan: _____

OBSTETRIC HISTORY (PREGNANCIES) List all deliveries:

Month/Day/Year	Vaginal/Cesarean	Weight/Weeks	Location	Sex of baby	Complications

FAMILY GENETICS SCREENING: (include patient, baby's father, or anyone in either family with:

	YES	NO		YES	NO
Patient age > or = 35 years			Hypertension		
Down syndrome			Twins		
Tay-Sachs (Jewish background)			Cancer		
Sickle cell disease or trait			Heart Disease		
Hemophilia			Intellectual Disabilities		
Muscular Dystrophy			Other inherited genetic or chromosomal disorder. Had child with birth defects		
Cystic Fibrosis			Patient or baby's father had a child with birth defects not listed above		
Huntington Chorea			> or = 3 First trimester spontaneous abortions or a stillbirth		
Diabetes			Medications or street drugs since last menstrual period? If yes, Agents		
Other significant family history?					

INFECTION HISTORY: (patient or partner)

	YES	NO		YES	NO
High risk AIDS			Rash or Viral illness since last menstrual period		
High risk Hepatitis B			History of STD, GC, Chlamydia, HPV, Syphilis		
Live with someone with TB			HIV Testing		
History of Genital Herpes			Other:		