DATE ____________________ REFERRED BY ______________________________

NAME ______________________________________ PRIMARY PROVIDER ____________________________
Last First Middle

Religious Consideration ______________________________

MENSTRUAL HISTORY

DAY / MONTH / YEAR **LMP** ________ _____Definite _____Unknown	Age of Onset	Cycle Q Days	Length Days	Due Date

PAST PREGNANCY HISTORY

	Date Month / Year	GA Weeks	Length of Labor	Birth Weight	Sex M / F	Type of Delivery	Anesthesia	Preterm Labor Yes / No	Comments
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Medications Since LMP	Start Date	Stop Date	Current Medications
1			1
2			2
3			3
4			4
5			5
6			6

Historical Risk Status

_____ No Risk Factors

_____ At Risk

_____ At High Risk

Drug Allergies ____

INITIAL PHYSICAL EXAMINATION

Date _____/_____/_____ Pregravida Weight ________ Height ________ BP ________

1 HEENT	__ Normal	__ Abnormal	12 VULVA	__ Normal	__ Condyloma	__ Lesions
2 TEETH	__ Normal	__ Abnormal	14 CERVIX	__ Normal	__ Inflammation	__ Lesions
3 THYROID	__ Normal	__ Abnormal	15 UTERUS SIZE	___ Weeks		__ Fibroids
4 BREASTS	__ Normal	__ Abnormal	16 ADNEXA	__ Normal	__ Mass	
5 LUNGS	__ Normal	__ Abnormal	17 RECTUM	__ Normal	__ Abnormal	
6 HEART	__ Normal	__ Abnormal	18 DIAGONAL CONJUGATE	__ Reached	__ No	__ CM
7 ABDOMEN	__ Normal	__ Abnormal	19 SPINES	__ Average	__ Prominent	__ Blunt
8 EXTREMITIES	__ Normal	__ Abnormal	20 SACRUM	__ Concave	__ Straight	__ Anterior
9 SKIN	__ Normal	__ Abnormal	21 SUBPUBIC ARCH	__ Normal	__ Wide	__ Narrow
10 LYMPH NODES	__ Normal	__ Abnormal	22 GYNECOID PELVIC TYPE	__ Yes	__ No	

Comments (Number and explain abnormals):

____

____

____

Exam by ______________________________

NAME ______________________________

SYMPTOMS SINCE LMP

	YES	NO	COMMENTS
1 HEADACHES			
2 NAUSEA / VOMITING			
3 ABDOMINAL PAIN			
4 URINARY COMPLAINTS			
5 VAGINAL DISCHARGE			
6 VAGINAL BLEEDING			
7 EDEMA			
8 RUBELLA EXPOSURE			
9 OTHER VIRAL EXPOSURE			
10 RADIATION EXPOSURE			
11 ______________			
12 ______________			
13 CONTRACEPTION PRIOR TO CONCEPTION TYPE: ______________ LAST USED: __________			

INFECTION HISTORY	YES	NO		YES	NO
1 HIGH RISK HEP. B / IMMUNIZED?			4 RASH OR VIRAL ILLNESS SINCE LMP		
2 LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5 HISTORY OF STD, GC, CHLAMYDIA, HPV, &/OR SYPHILIS		
3 PATIENT OR PARTNER HAS A HISTORY OF GENITAL HERPES			6 OTHER (SEE COMMENTS)		

PAST MEDICAL HISTORY

	o Neg. + Pos.	Detail Positive Remarks Include Date and Treatment		o Neg. + Pos.	Detail Positive Remarks Include Date and Treatment
1 DIABETES			16 LUNG (TB, ASTHMA)		
2 HYPERTENSION			17 DRUG ALLERGIES		
3 HEART DISEASE			18 HIST. OF ABNORM PAP		
4 AUTOIMMUNE DISEASE			19 UTERINE ANOMALY / DES		
5 KIDNEY DISEASE / UTI			20 INFERTILITY		
6 NEUROLOGIC / EPILEPSY			21 SURGERY / HOSPITAL STAY		
7 PSYCHIATRIC			(YR AND REASON)		
8 HEPATITIS / LIVER DISEASE			22 ANESTHETIC COMPLICATIONS		
9 VARICOSITIES / PHLEBITIS			23 CONGENITAL ANOMALIES		
10 THYROID DYSFUNCTION			24 GENETIC DISEASE		
11 TRAUMA / DOMEST. VIOLENCE			25 MULTIPLE PREG		
12 HISTORY OF BLOOD TRANFUS.			26 CANCER / MALIGNANCIES		
	AMT / DAY	AMT/DAY # YEARS	27 GI PROBLEMS		
	PREPREG.	PREG. USE	28 RHUEMATIC FEVER		
13 TOBACCO			29 ANEMIA		
14 ALCOHOL			30 BLOOD DISORDERS		
15 STREET DRUGS			31 INFECTIOUS DISEASE		

COMMENTS:

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