First Visit OB Form

Name ______________________ Age ______ Marital Status S M D W
Address ______________________ Occupation ______________
Father of the Baby ______________________ Involved Not Involved
Occupation ______________________

Last Menstrual Period __________ Certain Uncertain EDC ______________
Have you had a sono already done in the pregnancy? ______ When? ______ Where? __________
Previous Pregnancies and Miscarriages

Date	Weight	M/F	Wks	Vag or C/S	Epidural	Complications

Past Medical History ______________________
Past Surgical History ______________________
Allergies ______________________
Medications ______________________
Social History: Do you Smoke? Drink alcohol? Have you used any recreational drugs?
Marijuana? Cocaine? Crystal Meth? IV Drugs? Other?

Have you or your partner ever had any of the following:
Herpes? Gonorhea? Chlamydia? Syphilis? Hepatitis B? Hepatitis C? HIV? AIDS?

Have you had: chicken pox? immunization for chicken pox? a blood transfusion?
a TB Skin Test? immunization for Hepatitis?

Do you or your partner have a family history of: cystic fibrosis? muscular dystrophy?
sickle cell trait? sickle cell disease? any other inherited illness?

Have any family members had a child with birth defects? spina bifida? heart defects?

Are there relgious preferences or practices about which you would like for us to be aware?

Are you a Jehovah's Witness? Yes No

Other important information:

Signature ______________________ Date ______________