Initial OB Visit

Central Texas OB/GYN Associates

Updated 10/24/11

Name: | **Date:**

Husband's Name:

Cycles: ☐ Regualr ☐ Irregular

Date of last pap smear: ☐ Normal ☐ Abnormal

Type of pregnancy test: ☐ Blood ☐ Urine

When wasy pregnancy test performed: # Days

Quantity of menses: ☐ Very light ☐ Normal ☐ Light ☐ Heavy

Complaints since last menstrual period:

What symptoms have you experienced:

Past medical conditions:

Number of pregnancies:

Maternal Hx:
☐ Gestational Diabetes ☐ Preclampsia ☐ Preterm labor
☐ Hypertension ☐ Eclampsia ☐ Preterm delivery
☐ Pregnancy induced hypertension ☐ Hyperemesis gravidarum ☐ An incompetent cervix

Substance use: ☐ Alcohol ☐ Cocaine ☐ Amphetamines ☐ Tobacco ☐ Marijuana ☐ Street drugs

Weight changes: ☐ Weight gain ☐ Weight loss # of pounds:

Domestic violence: ☐ No ☐ Yes

Cats: ☐ Inside ☐ Outside ☐ No ☐ Yes

Close contact with children: ☐ No ☐ Yes

Chicken pox: ☐ No ☐ Yes

Patients age > / = 35 at EDC: ☐ No ☐ Yes

Thalassemia MCV < 80: ☐ Italian ☐ Mediterranean ☐ Greek ☐ Asian ☐ No ☐ Yes

Neural tube defect: ☐ Spina bifida ☐ Meningomyelocele ☐ Anencephaly ☐ No ☐ Yes

Congenital heart defect: ☐ No ☐ Yes

Down syndrome: ☐ No ☐ Yes

Tay-Sachs: ☐ Jewish ☐ French Canadian ☐ No ☐ Yes

Canavan's Disease: ☐ No ☐ Yes

Sickle cell disease or trait: ☐ African ☐ No ☐ Yes

Hemophila or other blood disorders: ☐ No ☐ Yes

Muscular dystrophy: ☐ No ☐ Yes

Cystic fibrosis: ☐ No ☐ Yes

Huntington's Chorea: ☐ No ☐ Yes

Mental retardation/autism: ☐ No ☐ Yes If yes, person tested for Fragile X: ☐ No ☐ Yes

Other inherited genetic or chromosomal disorder: ☐ No ☐ Yes

Maternal metabolic disorder: ☐ DM ☐ Other: ☐ No ☐ Yes ☐ PKU

Patient or FOB with a child with a birth defect not listed above: ☐ No ☐ Yes

Patinet or FOB with a birth defect themselves: ☐ No ☐ Yes

Recurrent pregnancy loss, or stillbirth: ☐ No ☐ Yes

Any medications since LMP other than prenatal vitamins: ☐ No ☐ Yes (include vitamins, supplements, OTC meds, drugs, alcohol)

Any other genetic/environmental exposure to discuss: ☐ No ☐ Yes

Lives with someone with TB or TB exposed: ☐ No ☐ Yes

Patient or partner has history of genital herpes: ☐ No ☐ Yes

Rash or viral illness since LMP: ☐ No ☐ Yes

History of STD: ☐ No ☐ Yes

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