



Appointment Date: _____

Name of your Obstetrician: _____

Obstetrician's Office Location: (City) _____

Reason for referral? _____

When was the 1st day of your last menstrual period? _____

What is your due date? _____ Is this a twin/triplet pregnancy? _____

What medications are you currently taking? _____

Are you taking Lovenox? _____ Do you have Rh negative blood type? _____

What is your pre-pregnancy weight? _____ Current Weight : _____ Height: _____

Do you have now or have you had any of the following conditions:

	current preg	prior preg
History of C-section		
History of surgery on cervix		
Pre-term labor		
Delivery of premature baby		
High blood pressure		
Diabetes or gestational diabetes		
Blood or clotting disorders		
Pregnancy by fertility treatment (ivf etc)		

How many times have you been pregnant including miscarriages, abortions, and children you have given birth to?

Miscarriage: (if any) _____ Abortions: (if any) _____

Children you have given birth to? (if any) _____ Ages: _____

Have you had any other pregnancy losses? _____

Are there any issues regarding your obstetrical or medical history that we should be aware of?

Please list any drug/latex allergies: _____

 Patient's signature

 Printed Patient's Name