

Greater Washington
Maternal-Fetal Medicine
 and **Genetics**



Appointment Date: _____

Name of your Obstetrician: _____

Office Location: (City) _____

When was the first day of your last menstrual period? _____

What medications are you currently taking? _____

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

current preg prior preg

Rh negative blood

History of C-section

Delivery of premature baby

Diabetes or gestational diabetes

Blood or clotting disorders

History of surgery on cervix

Pre-term labor

Pregnancy achieved by reproductive technology (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?

Why did your obstetrician refer you to our office? _____

Please list any drug allergies: _____

 Patient's Signature

 Printed Patients Name

