Greater Washington
Maternal
Fetal Medicine
& Genetics

Last Name______________________ Name__________________

Appointment Date: ________________ Date of Birth_____________

Name of your Obstetrician: ________________OB Office Location: (City) ___________________

Reason for referral? ____

How did you first hear about us? (Please Circle one) –OB referral, -Friend or Family member, -Website, -Yellow pages- other (please specify)____

When was the 1st day of your last menstrual period? __________________________________
What is your due date?_____________________is this a twin/triplet pregnancy? ___________

Was this pregnancy achieved by fertility treatment : No, IVF IUI other (please circle one)

Was this pregnancy achieved by donor egg?_______If yes, donor egg age?________________

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:____ BMI:_____

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

	Pregnancies Current	Prior
History of C-section		
History of surgery on cervix		
Pre-term labor		
Delivery of premature baby		
High blood pressure		
Diabetes/gestational diab.		
Blood or clotting disorders		

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) ______Weeks/GA at Birth?: _________ Ages now:__________

Have you had any other pregnancy losses? ____

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

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Please list any drug/latex allergies: ____

______________________________ ______________________________
Patient's signature Printed patient's Name

For office staff only

MD's initials__________ Sonographer's initials__________