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Accredited with the American Institute of Ultrasound in Medicine  
 and by the Fetal Medicine Foundation

Reason(s) for today's appointment \_\_\_\_\_

Is this pregnancy a result of reproductive technology? (IVF, IUI, ICSI, donor egg, etc.) yes \_\_\_\_\_ no \_\_\_\_\_

Please list previous pregnancies below in chronological order, beginning with most recent:

	YEAR	FULL TERM	LESS THAN 37 WEEKS	MISCARRIAGE	TERMINATED	WEEKS	VAGINAL	C-SECTION	BABY'S WEIGHT	BABY'S SEX	HRS IN LABOR
1st											
2nd											
3rd											
4th											
5th											
6th											

**GYNECOLOGIC HISTORY**

	YES	NO	DATE TREATED	IF YES, EXPLAIN
Abnormal pap smears				
Treatment to cervix (laser, LEEP, biopsy)				
Herpes				
Gonorrhea, Syphilis, Chlamydia				
Condyloma (warts)				
ovarian cysts				
fibroid or fibroid surgery (myomectomy)				
pelvic surgery				

Height \_\_\_\_ ' \_\_\_\_ " Pre-pregnancy weight \_\_\_\_ lbs

**SOCIAL HISTORY**

	YES	NO	EXPLAIN
Do you currently smoke cigarettes?			packs per day ____
Do you currently drink alcohol?			drinks per day ____
Do you use street drugs?			list

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**MEDICAL HISTORY**

	Y	N	DATE DIAGNOSED	MEDICATIONS/TREATMENT/EXPLAIN
Diabetes				
			If Yes,	Doctor's Name/Phone
Hypertension				
			If Yes,	Doctor's Name/Phone
Thyroid Disease				
			If Yes,	Doctor's Name/Phone
Rh Negative Blood				
Blood Transfusion				
Clotting Disorder, History of blood clot				
Bleeding Disorder				
Depression/Anxiety disorders				
Seizure disorder, headaches, migraines				
Asthma				
Heart Disease				
Eating disorder				
Stomach problem, obesity surgery, eating disorder				
Gallstones or Gall Bladder problem				
Liver disease, hepatitis, jaundice				
Kidney disease, stones				
Arthritis, rheumatism, bone or joint problems, Lupus				
Tuberculosis, Positive PPD				
Cancer				

**MEDICATIONS (including vitamins and supplements)**

MEDICATION NAME	DOSE	# TIMES TAKEN DAILY	DATE STARTED

**LIST ALL DRUG ALLERGIES (CHECK HERE IF NONE \_\_\_\_\_)**

MEDICATION NAME	REACTION: (ITCHING, NAUSEA, HIVES, SHOCK)	DATE LAST TAKEN

**LIST ALL SURGERIES BEGINNING WITH MOST RECENT (CHECK HERE IF NONE \_\_\_\_\_)**

PROCEDURE PERFORMED	YEAR	COMPLICATIONS, IF ANY