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

MFAMA
Maternal Fetal Associates
Of The Mid-Atlantic, LLC.

Patient Name: _____

Patient DOB: _____/ _____/ _____

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	MISCAR-RIAGE	TERMIN-ATED	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, Syphillis, 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

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