Southwest Medical®
Part of OptumCare®

Obstetric Medical History Form

Patient name: _____ Birth date: _____

Age: _____ Medical record number: _____ Today's date: _____

Date of last menstrual period? _____

Have you or your partner traveled to a Zika-affected region?
Yes _____ No _____ I don't know _____

Check the follow infections or Sexually Transmitted Disease (STD or Venereal Disease) you have had in the past. None _____

Hepatitis _____
(B _____ or C_____)

Chlamydia _____

Syphilis _____

Gonorrhea
(GC/Clap)_____

Herpes _____
(Genital _____ or Oral _____)

Were you using birth control? Yes _____ No _____
If yes, what type? _____

Marital status:

Single _____

Married _____

Living with Partner _____

Widowed _____

Divorced/Separated _____

Occupation: _____

Do you have any history of: Sexual abuse _____ Domestic abuse _____
Are you safe now? Yes _____ No _____

Past pregnancies

	1	2	3	4	5
Delivery Date (mm/dd/yyyy)					
Weeks at Delivery					
Length of Labor					
Birth Weight					
Sex (m/f)					
Vaginal or C/Section					
Epidural or General Anesthetic					
Hospital of Delivery					
Beta Strep + (y/n)					
Pre-term Labor					
Complications (y/n)					

	6	7	8	9	10
Delivery Date (mm/dd/yyyy)					
Weeks at Delivery					
Length of Labor					
Birth Weight					
Sex (m/f)					
Vaginal or C/Section					
Epidural or General Anesthetic					
Hospital of Delivery					
Beta Strep + (y/n)					
Pre-term Labor					
Complications (y/n)					

Prescription / OTC Medications None _____

Medication name	Dosage

List medications you are allergic to:

No known drug allergies _____ Latex allergy? Yes _____ No ____

Medication name	Reaction

Tobacco use: Yes _____ No____ Amount pre-pregnancy _____ Amount now _____

Alcohol use: Yes _____ No____ Amount pre-pregnancy _____ Amount now _____

Illicit/Recreational drugs: Amount pre-pregnancy _____ Amount now _____
Yes ____ No_____

Medical conditions:	**Yes/No**		**Yes/No**
Neurologic problems / Epilepsy		Operations / Hospitalizations, please list below:	
Depression / Postpartum depression			
Psychiatric problems			
Pulmonary issues / Asthma / TB exposure			
Seasonal allergies			
Immune system disorders			
Low / High thyroid			
Hypertension / Heart disease		Female surgery:	
Diabetes		Myomectomy	
Kidney disease / Urinary tract infections		Fibroid removal	
Pulmonary issues / Asthma / TB exposure		Ovary removed	
Blood disorders / Blood transfusions		Ectopic pregnancy	
Varicosities / Blood clots		Leep / Cold knife cone	
RH negative blood type		Other	
Hepatitis / Liver disease		Other / Relevant family history, please list below:	
Stomach problems			
Skin problems			
Cancer / Breast cancer			
Uterine abnormalities			
Infertility / Reproductive assistance			
Anesthetic complications			

Genetic screening (patient history, father of the baby, or anyone in either family) **Yes/No**

Thalassemia (Italian, Greek, Mediterranean, or Asian)	
Neural tube defect (Meningomyelocele, Spina Bifida, or Anencephaly)	
Congenital heart defect	
Down Syndrome	
Tay-sachs (EF, Ashkenazi Jewish, Cajun, French Canadian)	
Canavan disease (Ashkenazi Jewish)	
Sickle cCell disease or trait (African)	
Hemophilia or other blood disorders	
Muscular Dystrophy	
Cystic Fibrosis	
Huntington's Chorea	
Fragile X Syndrome	
Other inherited genetic or chromosomal disorder	
Maternal metabolic disorder (Type 1 Diabetes, PKU)	
Patient or baby's father had a child with birth defects not listed above	
Recurrent pregnancy loss or stillbirth	
Rash or viral illness since last menstrual period	

This form is confidential and part of your medical record.

Patient signature: _____

Medical provider: _____

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請注意：/如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電： 702-877-5199