MountainStar Healthcare

Lakeview OB/GYN Clinic

Today's Date_____

Patient Name_____ DOB:_____
(First) (Last) (Maiden)

Father of Baby:_____ DOB:_____
(First) (Last)

Number to contact father in case of emergency_____

Pregnancy History

How many times have you been pregnant?_____ How many live births?_____
How many miscarriages?_____ How many abortions?_____
Date of last period:_____ Date of last pap smear?_____

1st baby	2nd baby	3rd baby
Date of birth:_____	Date of birth:_____	Date of birth:_____
Weeks at time of delivery:_____	Weeks at time of delivery:_____	Weeks at time of delivery:_____
Length of labor:_____	Length of labor:_____	Length of labor:_____
Baby's weight:_____	Baby's weight:_____	Baby's weight:_____
Baby's sex:_____	Baby's sex:_____	Baby's sex:_____
Vaginal or C-section:_____	Vaginal or C-Section_____	Vaginal or C-Section_____
Anesthesia:_____	Anesthesia:_____	Anesthesia:_____
Place of delivery:_____	Place of delivery:_____	Place of delivery:_____

Medical History

Are you allergic to any medication? Yes____ No____ If yes, please list:_____
Do you have any of the following conditions?

Cancer:_____	Heart disease:_____	High blood pressure:_____
Asthma:_____	Bowel disorder:_____	Stomach/ulcer disease:_____
Diabetes:_____	Thyroid problems:_____	Kidney/urinary disease:_____
Hepatitis:_____	Blood Clots, leg/lungs:_____	Seizure/neurological disorder:_____

Genetic History

Is there any family history (mother or father) of any of the following conditions?

Down syndrome:____	Autism:_____	Cystic Fibrosis:_____	Other birth defects:_____
Muscular dystrophy:_	Spina bifida:__	Thalassemia:_____	_____

Current Medications

Name and dosage (Please continue on back of page, if needed)

_____ _____
_____ _____

Social History

Any alcohol use? Yes____ No____ If yes, how many per occasion? _____
Any tobacco use? Yes____ No____ If yes, how many per occasion?_____
Any caffeine use? Yes____ No____ If yes, how many per occasion?_____
Any drug use? Yes____ No____ If yes, how many per occasion?_____

Surgical History

Year and type of surgery (Please continue on back of page if needed)

_____ _____
_____ _____

Family History (any female family member, ie grandmother, mother, sister, aunt)

Breast Cancer_____ Cervical cancer_____ Ovarian cancer_____ Uterine Cancer_____

Do you have an "**Advanced Directive**" Yes____ No____ If yes, what type?_____