College Park Family Care – Lenexa

First Obstetric Visit Form

Name:____ Date of Birth __/__/____ Age: ______ Today's Date: __/__/____

Congratulations on your pregnancy! Please fill out as much information as you can before your first OB visit. This form will help us efficiently find what your unique health needs are, and any precautions to take so that your child is as healthy as possible. If you have any questions along the way we will address them during the visit. Thank you!

Gynecologic History:

Circle Yes or No, and include any appropriate additional details

Last Menstrual Period (first day of last period)		Date:	Age First Started Periods	
Previous Pap Smear	No/Yes	Date:	Monthly Menstruation/ Frequency of Periods	
Past Birth Control	No/Yes	Date:	On Birth Control at Conception	No/Yes

Father of Baby Information

Father's First Name:	Last Name: Middle Initial:
Father's Date of Birth: _____/______/________	Occupation:
Father's Phone: (_______)__________________ Cell Phone (if different): ____________________	Race: ____________________ Ethnicity: Hispanic or Latino - Yes/No

OB Flowsheet History

Does the mother of the baby have ANY history of the items listed below? Write in comments/details as needed.

Tobacco	No/Yes	
Diabetes	No/Yes	
Hypertension	No/Yes	
Depression/Post Partum Depression	No/Yes	
Alcohol	No/Yes	
Illicit/Recreational Drugs	No/Yes	
Infertility	No/Yes	
History of Abnormal PAP	No/Yes	
Kidney Disease/UTI	No/Yes	
Heart Disease	No/Yes	
AutoImmune Disorder	No/Yes	
Neurologic/Epilepsy	No/Yes	
Hepatitis/Liver Disease	No/Yes	
Varicosities/Phlebitis (Varicose veins/blood clots)	No/Yes	
Thyroid/Dysfucntion	No/Yes	
Trauma/Violence/Sexual Abuse	No/Yes	
History of Blood Transfusion	No/Yes	
Pulmonary (TB Asthma)	No/Yes	
Seasonal Allergies	No/Yes	
Drug/Latex Allergies/Reactions	No/Yes	
Breast Issues	No/Yes	

GYN Surgeries	No/Yes	
Anesthetic Complications	No/Yes	
Operations/Hospitalization	No/Yes	
Uterine anomaly/prescribed DES (was your mother on hormones when pregnant with you)	No/Yes	

Genetics History – *Is there ANY family history (mother of baby, mother's side, father of baby, father's side) of the genetic issues below? If a certain disease is unfamiliar, feel free to ask if you are unsure how to respond.*

Mother of baby older than 35 years	No/Yes	
Thalassemia (Italian, Greek or Mediterranean or Asian); MCV<80	No/Yes	
Neural Tube Defect (Spina Bifida)	No/Yes	
Congenital Heart Defect	No/Yes	
Down Syndrome	No/Yes	
Tay-Sachs	No/Yes	
Canavan disease	No/Yes	
Sickle cell disease or trait	No/Yes	
Hemophilia or other blood disorders	No/Yes	
Muscular dystrophy	No/Yes	
Cystic Fibrosis	No/Yes	
Huntington's Chorea	No/Yes	
Mental Retardation/Autism	No/Yes	
- If yes, was person tested for Fragile X	No/Yes	
Other inherited genetic or chromosomal disorder	No/Yes	
Maternal metabolic disorder	No/Yes	
Patient or baby's father had a child with birth defects not listed	No/Yes	
Recurrent pregnancy loss or stillbirth	No/Yes	
Medications/Illicit/Recreational drug/alcohol since last menstrual period	No/Yes	
If yes, Agent(s) and strength/dosage	No/Yes	

Infection History – *Is the following true for mother of the baby?*

Live with someone with TB or exposed to TB	No/Yes	
Patient or partner with genital herpes	No/Yes	
Rash or viral illness since last menstrual period	No/Yes	
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis	No/Yes	

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Risks – *Is the mother of baby at risk for or have history of the following?*

Anemia	No/Yes	
Uterine/Cervical Malformation	No/Yes	
Rh Negative (nonsensitized)	No/Yes	
Venereal disease (STD)	No/Yes	
Acute pyelonephritis (kidney infection)	No/Yes	
Failure to gain weight	No/Yes	
Abnormal presentation (breach)	No/Yes	
Postterm pregnancy (≥42 weeks)	No/Yes	
Alcohol use	No/Yes	
Suspect pelvis	No/Yes	
Uterine bleeding	No/Yes	
Diabetes mellitus	No/Yes	
Hypertension	No/Yes	
Rh sensitization	No/Yes	
Thrombophlebitis (infection/ inflammation of veins)	No/Yes	
Herpes	No/Yes	
Hydramnios (excess fluid around baby)	No/Yes	
Severe preeclampsia (HTN in pregnancy)	No/Yes	
Fetal growth retardation	No/Yes	
Premature ruptured membranes (water breaks before labor)	No/Yes	
Multiple pregnancy (preterm)	No/Yes	
Alcohol or drug abuse	No/Yes	
Advanced maternal age (>35 years old)	No/Yes	

Past Pregnancies

Total Pregnancies	Full Term Pregnancies	Premature (<37 weeks)	Abortion Induced	Miscarriage	Ectopic Pregnancies	Multiple Births	Living Children

Child	Date of Birth	Gestational Weeks	Length of Labor	Birth Weight	Sex (M/F)	Type of Delivery	Anesthetic Used	Place of Delivery	Preterm Labor (Y/N)
1									
2									
3									
4									
5									
6									
7									

Additional Questions or Concerns: