PageMed
HEALTHCARE WITHOUT BORDERS

History Form

Name ________________________________ OB Doctor __________________ Medical Record #__________

Date of Birth______________________ Age at time of Delivery: ________

Allergic to: Medication? ☐ Yes ☐ No Yes, list meds _________________ Allergic to Latex? ☐ Yes ☐ No

Current Medications and Dosage: ____

Reason for Ultrasound ____

Problems this pregnancy ____

Last Menstrual Period ________________ Due date your doctor's using (EDD)____________________

Prior ultrasounds this pregnancy when/where____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR PREVIOUS DELIERIES:

Delivery Date Month/Year	How far along were you?	Baby's Birth Weight	Vaginal Delivery Or C-Section	Complications or Abnormalities

PATIENT'S OBSTESTRIC HISTORY

How many pregnancies? Include this pregnancy, still births, miscarriages or abortions? G_____

How many premature deliveries have you had (before 37 weeks)? P_____

How many terms deliveries have you had (after 37 weeks)? T _____

How many miscarriages or abortions have you had? A_____

How many children are currently living? L_____

Have you ever had a tubal (ectopic) pregnancy? If yes, how many? _____

Surgeries: ____

Check appropriate box if you have had the following:

☐ High blood pressure in pregnancy
☐ Pressure
☐ Vaginal Bleeding
☐ Abnormal Discharge
☐ Death of a child
☐ Baby over 9 pounds
☐ Baby under 5 pounds
☐ Diabetes- Type 1
☐ Diabetes-Type 2
☐ High blood pressure
☐ Other

☐ Bleeding disorder
☐ Leaking Fluid
☐ Preeclampsia/toxemia
☐ Cramping
☐ Kidney Disease
☐ Heart Disease
☐ Mitral Disease
☐ Seizures
☐ Sickle cell disease
☐ Blood clots

☐ Gestational diabetes
☐ Anemia
☐ Lupus
☐ HIV/Aids
☐ Asthma
☐ Hepatitis
☐ Smoking
☐ Alcohol
☐ Recreational Drugs
☐ Family history of birth defects, mental retardation, down syndrome

The information I have provided about my medical history is accurate to the best of my knowledge:

______________________________ ______________________
Patient's Signature Date

______________________________ ______________________
Medical Provider Signature Date