

Name \_\_\_\_\_

Doctor \_\_\_\_\_

Tulsa Women's Health Care

What was your baseline weight? (right before you got pregnant)  
\_\_\_\_\_ lbs

What was the first day of your last menstrual period? (if unknown, give your best guess)  
\_\_/\_\_/\_\_

How old were you when you first started your period?  
\_\_\_\_\_ yrs old

Are your periods regular?

\_\_\_\_\_  
If so, how many days does your cycle normally run?  
\_\_\_\_\_ days

How long do you normally bleed with your period?  
\_\_\_\_\_ days

How much did you weigh at birth?  
\_\_\_\_\_ lbs \_\_\_\_\_ oz

How much did your partner weigh at birth?  
\_\_\_\_\_ lbs \_\_\_\_\_ oz

Do you have any history of traumatic births in your family?

\_\_\_\_\_  
If so, please describe:

\_\_\_\_\_  
Please list all previous pregnancies, including any miscarriages and elective abortions:

DOB	miscarriage or abortion	gestational age	vaginal or cesarean	length of labor (hrs)	hospital	sex and weight of baby	child's name

Were there any complications with any of your previous pregnancies or deliveries? If so, please describe:

\_\_\_\_\_  
Please indicate if you have or have had any of the following medical conditions.

- |   |                         |
|---|-------------------------|
| ___ allergic rhinitis                   | ___ autoimmune disorder |
| ___ anemia or other blood disorders     | ___ breast disorder     |
| ___ asthma or other pulmonary disorders | ___ depression          |

psychiatric disorder  
 diabetes  
 infertility  
 liver disease  
 neurologic disorder  
 renal disease  
 (Rh) sensitized  
 thyroid disorder

heart disease  
 hypertension (high blood pressure)  
 trauma history  
 uterine abnormalities  
 varicosities/ DVT (blood clots)  
 anesthetic complications  
 other family history  
 other

If you checked yes to any of the above, please explain:

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Have you ever had a blood transfusion?

If so, when?

When was your last pap smear?

Have you ever had an abnormal pap smear?

If so, when?

Have you ever had any surgeries on your cervix, or have you ever had to have any part of your cervix frozen?

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Since finding out you were pregnant, have you used any:

alcohol

If so, how many drinks per day? \_\_\_\_\_

tobacco

If so, what kind? \_\_\_\_\_

How much per day? \_\_\_\_\_

drugs

If so, what kind? \_\_\_\_\_

How much per day? \_\_\_\_\_

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Have you ever had any surgeries or hospitalizations (other than childbirth?)

surgery or hospitalization	when? (year)	comment

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Does anyone in your family or your partner's family have any history of any genetic abnormalities?

- Neural Tube Defect (Spina Bifida, Anencephaly)
- Trisomy 21 (Down's Syndrome)
- Congenital Heart Defect
- Cystic Fibrosis
- Tay-Sachs (Jewish, Cajun, French-Canadian)
- Thalassemia (Italian, Greek, Mediterranean, Asian)
- Canavan Syndrome
- Hemophilia or Hematologic Disease
- Huntington's Chorea
- Autism
- If so, was this person tested for Fragile X?
- Mental Retardation
- If so, was this person tested for Fragile X?
- Muscular Dystrophy
- Sickle Cell Disease or Trait (African)
- Other Inherited Genetic or Chromosomal Disorder
- Maternal Metabolic Disorder (Type I Diabetes, PKU)
- Recurrent Pregnancy Loss, or a Stillbirth
- Other Birth Defects
- Other Genetic Screening

If you answered yes to any of the above, please explain who has the disorder:

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Have you or your partner ever had:

- HIV or AIDS
- genital herpes
- any other STDs

If yes, please explain who had the disease and if treatment was received.

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Have you ever been exposed to TB (tuberculosis)?

\_\_\_\_\_  
If so, please explain if you had negative tests, or received treatment.

\_\_\_\_\_  
Have you had any kind of rash or viral illness since your last menstrual period?

\_\_\_\_\_  
If so, please explain.

\_\_\_\_\_  
Have you ever had chicken pox?

\_\_\_\_\_  
Have you had any other significant exposure or history of infection?

\_\_\_\_\_  
If so, please explain.

\_\_\_\_\_  
Please list any and all medications you are currently taking.

Medication	Dosage

Please list all medications that you are allergic to.

Medication	Reaction

