Atlanta Perinatal Associates

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