

Associates in Women's Health, P.A.

New OB Work-Up Sheet

Demographic Data

Name _____

Social Security# _____ Date of Birth _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Race/Ethnicity/Birthplace _____

Education _____ Occupation _____

Marital Status: Single Married Separated Divorced Widowed Partnered

Primary/Referring Doctor _____

Newborn Provider _____

Emergency Contact _____ Phone # _____

Father of Baby /Partner _____ Race/Ethnicity _____

Education _____ Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Menstrual History

Age at 1st Menstrual period _____ Menstrual Frequency _____ days Length of bleeding _____ days

LMP _____ Was your last period normal Y N Dates certain? Y N

Prior contraception _____

Contraception stopped _____

Bleeding since LMP? Y N Fever since LMP? Y N

Date of positive pregnancy test _____ Blood Urine

Medications/Street drugs/Alcohol since LMP? Y N List: _____

Total # pregnancies	Full term	Preterm	Miscarriage/Abortion	Living
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Past Pregnancies Including Miscarriages and Abortions

Date Mo/Day/Yr	Gest. Weeks	Length of Labor	Birth Weight	Sex M/F	Type Delivery	Anes.	Place of Delivery	Preterm Labor Yes/No	Gestational Diabetes Yes/No	Comments/ Complications

Past Medical History

Condition	Patient	Family	Condition	Patient	Family
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	Y	N	Y	N	Patient	Y	N	Y	N
1. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Pulmonary (TB, asthma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Allergies (Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Gyn Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Autoimmune Disorder (Lupus/Antiphospholipid Synd.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Operations/Hospitalizations (Year and Reason—list below)	<input type="checkbox"/>	<input type="checkbox"/>		
5. Kidney Disease / UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Anesthetic Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Neurologic (Epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. History of abnormal Pap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric (Anxiety/Depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Uterine anomaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Hepatitis / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. DES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Varicosities / Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Relevant Family History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Trauma / Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. History of Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. None of the above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Infection History/Workplace Environment Risk

Condition	Patient Y N	Partner Y N	Condition	Patient Y N	Partner Y N
1. HIV/Risk Factors	<input type="checkbox"/>	<input type="checkbox"/>	10. Exposed to cat litter	<input type="checkbox"/>	<input type="checkbox"/>
2. Used IV Drugs	<input type="checkbox"/>	<input type="checkbox"/>	11. Exposed to lead or chemicals	<input type="checkbox"/>	<input type="checkbox"/>
3. Immunized for Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	12. Exposed to radiation	<input type="checkbox"/>	<input type="checkbox"/>
4. Live with Someone with TB or Exposed to TB	<input type="checkbox"/>	<input type="checkbox"/>	13. Exposed to infections (hospital, lab work, day care, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient or Partner has history of Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	14. Is there a high level of stress at work/home	<input type="checkbox"/>	<input type="checkbox"/>
6. Rash or Viral Illness since last Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>	15. Stands for prolonged periods of time	<input type="checkbox"/>	<input type="checkbox"/>
7. History of STD, GC, Chlamydia, HPV, Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	16. Sits for prolonged periods of time	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had chicken pox or been immunized	<input type="checkbox"/>	<input type="checkbox"/>	17. Lifts heavy objects repeatedly	<input type="checkbox"/>	<input type="checkbox"/>
9. DT immunization up-to-date?	<input type="checkbox"/>	<input type="checkbox"/>	18. Other	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Attitude towards pregnancy: Planned Unplanned Plan to parent/keep Adoption

Drug use: (Past/Current):

Tobacco Y N Pre-Pregnancy amt. _____ Pregnancy amt. _____ Yrs. Total use _____

Alcohol Y N Pre-Pregnancy amt. _____ Pregnancy amt. _____ Yrs. Total use _____

Caffeine Y N Pre-Pregnancy amt. _____ Pregnancy amt. _____ Yrs. Total use _____

Street Drugs Y N List: _____ Counseling/Referral Y _____

Partner/Spouse drug use _____

Genetic Screening History

Have you or any members of your family been born with or affected by any known genetic problem, birth defects, or major medical problems?

	Patient	Baby/Father of	Family		Patient	Baby/Father of	Family
1. Patient's Age ≥ 35 yrs.	<input type="checkbox"/>			10. Cystic Fibrosis or any other metabolic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Father of baby ≥ 50 yrs.		<input type="checkbox"/>		11. Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Italian, Greek Mediterranean or Asian background (thalassemia)	<input type="checkbox"/>	<input type="checkbox"/>		12. Mental retardation or autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Jewish, Cajun, Fr. Canadian background (Tay Sachs)	<input type="checkbox"/>	<input type="checkbox"/>		13. Maternal medical problems (diabetes, lupus, epilepsy, PKU, etc.)	<input type="checkbox"/>		
5. African or Latin American background (sickle cell)	<input type="checkbox"/>	<input type="checkbox"/>		14. Other inherited genetic or chromosomal disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Down syndrome or other chromosomal problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Child with birth defects not listed above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Hemophilia or other bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. ≥ 3 first trimester spontaneous abortions or a stillbirth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Adopted—family history unknown	<input type="checkbox"/>	<input type="checkbox"/>		18. None of the above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>