Initial Prenatal History

Welcome to Fulton County OB/GYN. As a new patient, please fill out the information found below to the best of your ability. Thank You!

PATIENT NAME_____ **BIRTHDATE**_____ **AGE**____

MARITAL STATUS_____ **OCCUPATION/ EMPLOYER**_____

PARTNER/BABY'S FATHER_____ **TELEPHONE**_____

FATHERS ADDRESS_____

FATHERS OCCUPATION/ EMPLOYER_____

ALLERGIES

_____

MEDICATIONS

_____

_____

NON-SCRIPT, HERBALS AND SUPPLEMENTS_____

PREVIOUS HOPITALIZATIONS OR SURGERIES WITH DATES

_____

_____

LIFESTYLE/ OTHER ISSUES

USE OF ALCOHOL: NEVER___ RARELY___ MODERATE___ DAILY___

USE OF TOBACCO: NEVER___ RARELY___ MODERATE___ DAILY___

Packs per day_____ Have you quit? ☐ Yes ☐ No Start_____ Stop_____

USE OF STREET DRUGS: NEVER___ RARELY___ MODERATE___ DAILY___

Have you had exposure to second hand smoke? ☐ Yes ☐ No

Have you ever been immunized against the HPV virus (Gardasil) - ☐ Yes ☐ No

Have you received the tetanus, diphtheria, pertussis(Tdap) vaccine? ☐ Yes ☐ No
If so, when? _____

Do you want to be tested for HIV today? ☐ Yes ☐ No

FAMILY HISTORY (please indicated yes or no and which relative)

	Yes	**Who**			
Diabetes	____	_____	Breast Cancer	____	_____
High Blood Pressure	____	_____	Ovarian Cancer	____	_____
Stroke	____	_____	Uterine Cancer	____	_____
Heart Disease	____	_____	Twins	____	_____
Birth Defects	____	_____	Other	_____	

MENSTRUAL/OBSTETRICAL HISTORY

Age of First period_____ Date of last period (1st day)_____ Frequency_____

Was you last cycle normal? Yes ☐ No **How long do you cycles last? _____**

Type of last Birth Control used? _____ Dates_____

DATE/RESULT OF LAST PAP_____ History of Abnormal Pap? ☐ Yes ☐ No

Total # of pregnancies____ Full Term Births____ Pre- term Births____
Miscarriages____ Abortions____ Ectopic____ Multiples___ Living Children____

Pregnancies

#1)Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
Place of Birth_____ Complications_____

#2)Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
Place of Birth_____ Complications_____

#3)Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
Place of Birth_____ Complications_____

#4)Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
Place of Birth_____ Complications_____

#5)Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
Place of Birth_____ Complications_____

#6)Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
Place of Birth_____ Complications_____

Review of Systems (DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS)

GENERAL
☐ WEAKNESS ☐ FATGIUE ☐ FEVER ☐ WEIGHT GAIN ☐ WEIGHT LOSS

CARDIOVASCULAR
☐ CHEST PAIN
☐ DIZZINESS
☐ PALPITATION
☐ SHORTNESS OF BREATH

RESPIRATORY
☐ CHRONIC COUGH
☐ SHORTNESS OF BREATH
☐ WHEEZING

GASTROINTESTINAL
☐ ABDOMINAL PAIN
☐ CHANGE IN BOWEL MOVEMENTS
☐ RECTAL BLEEDING
☐ NAUSEA OR VOMITING
☐ FREQUENT DIARRHEA
☐ CONSTIPATION

GENITOURINARY/FEMALE
☐ FREQUENT URINATION
☐ BURNING/PAINFUL URINATION
☐ BLOOD IN URINE
☐ INCONTINENCE OR DRIBBLING
☐ KIDNEY STONES
☐ PAIN WITH PERIODS
☐ IRREGULAR PERIODS
☐ VAGINAL DISCHARGE

EYES, EARS, NOSE, THROAT
☐ VISION CHANGES
☐ EAR RINGING
☐ SINUS DRAINAGE
☐ THROAT/NECK/EAR PAIN

MUSCULOSKELETAL
☐ JOINT PAIN, STIFFNESS, OR SWELLING
☐ MUSCLE PAIN OR WEAKNESS
☐ BACK PAIN

SKIN/BREAST
☐ RASH OR ITCHING
☐ CHANGE IN HAIR OR NAILS
☐ VARICOSE VEINS
☐ BREAST PAIN
☐ BREAST LUMP
☐ BREAST DISCHARGE

NEUROLOGICAL
☐ FREQUENT HEADACHES
☐ SEIZURES
☐ LIGHT HEADED OR DIZZY
☐ NUMBNESS OR TINGLING

HEMATOLOGIC/LYMPHATIC
☐ PROLONGED BLEEDING
☐ EASY BRUISING
☐ SWOLLEN GLANDS

The questions on this form are answered correctly to the best of my knowledge. It is my responsibility to inform the office of any changes in my medical status. I also authorize the staff to perform the necessary services which I may need.

_____ _____
Signature of patient (Parent/Guardian/P.O.A) Today's Date