



**Obstetrics and Gynecology Specialists
New OB Worksheet**

S. Larson, M.D.
B. Colwell, M.D.
N. Bains, M.D.
A. Song, M.D.
K.A. Shibley, M.D.
S. Cho, M.D.

M. Nickel, RN, CNP
R. Slack, RN, CNP
D. Bowker, RN, CNP

6545 France Ave. So., Edina, MN 55435

Reviewed _____

305 E. Nicollet Blvd., Burnsville, MN 55337

Name _____ Account # _____ Date _____

Date of Birth ____/____/____ Age at Delivery _____ Language: English Other _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Race/Ethnicity/Birthplace _____

Education _____ Occupation _____

Pre-Pregnancy Weight _____

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 ____ yrs. Menstrual Frequency _____ days Length of bleeding _____ days

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

Prior contraception _____

Contraception stopped: Date _____ Type _____

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
---------------------	-----------	---------	----------------------	--------

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	
	Y	N	Y	N		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"/>

Comments: _____

Infection History/Workplace Environment Risk

Condition	Patient		Partner		Condition	Patient		Partner	
	Y	N	Y	N		Y	N	Y	N
1. HIV/Risk Factors	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Exposed to lead or chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Immunized for Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Exposed to radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Live with Someone with TB or Exposed to TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Exposed to infections (hospital, lab work, day care, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient or Partner has history of Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<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"/>	<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	Father of Baby	Family		Patient	Father of Baby	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"/>