CPG Maternal Fetal Medicine – History Form

Name: _____ Birth Date: _____ Today's Date: _____

Referred by: _____Reason for Visit: _____

Personal Health History:

When was the first day of your last menstrual period? _____ How tall are you? _____ Last weight? _____

What is your due date? _____ What is your feeding plan? Breast___ Bottle___ Undecided___

How was your due date determined? (Please Check) ☐Unsure ☐Ultrasound ☐Last Menstrual Period ☐IVF ☐Known Conception

Please tell us about any pregnancies you have had. Start with the first one. Include miscarriages. If you need more room, use the back.

Delivery Date	Weeks of Gestation*	Cesarean, Vaginal, Vacuum, Forceps	Baby Weight	Gender	Hospital	Complications

*A normal pregnancy is about 40 weeks from the first day of the last menstrual period.

What type of work do you do? _____

Please list previous surgeries. Include any surgery on your uterus/cervix such as LEEP procedures. Note the year of the surgery:

Surgery:

_____ _____

_____ _____

_____ _____

Please note any genetic testing (e.g. MaterniT21, NIPS, First Trimester or Quad Screen) you have already had this pregnancy:

_____

Please describe any family genetic disorders or birth defects:

_____

Please check any of the following conditions that you **currently have or have had in the past:**

☐ Chronic hypertension	☐ Lupus	☐ Thyroid problems	☐ ADHD	☐ Bleeding disorder
☐ History DVT/PE	☐ Cancer/s	☐ HIV/AIDS	☐ Anxiety	☐ Asthma
☐ High Cholesterol	☐ Crohn's Disease	☐ Hepatitis B	☐ Depression	☐ Cystic Fibrosis
☐ Heart Disease	☐ Ulcerative Colitis	☐ Hepatitis C	☐ Bipolar Disorder	☐ Anemia
☐ Fibromyalgia	☐ Chronic Kidney Disease	☐ Tuberculosis	☐ PTSD	☐ Breast problems
☐ Rheumatoid Arthritis	☐ Frequent UTI's	☐ Chlamydia	☐ Hx Suicide Attempt	☐ Diabetes
☐ Migraines	☐ Kidney Stones	☐ Gonorrhea	☐ Alcoholism	☐ Other (describe below)
☐ Multiple Sclerosis	☐ Gallstones	☐ Herpes	☐ Chemical Dependency	
☐ Seizure Disorder	☐ Liver Disease	☐ Eating Disorder		

Please tell us more about the conditions you circled above (when diagnosed, how long, associated problems, etc.).

_____

_____

_____

Have you had any change in your ability to care for yourself? Yes____No____ If yes, please explain: _____

Do you use caffeine? Yes____No____ Type_____ How much?_____

Any change in Nutrition? Yes____No____ Type of Diet: _____

How do you learn best? Audio____Video____Verbal____Demonstration____Written____No preference____

Do you have any barriers to learning? (language, reading, hearing, etc) Yes____No____

Do you have any cultural or spiritual needs? Yes____No____

Do you have a Religious preference? Yes____No____

Signature:_____ **Revised 2/4/2021**