Kansas City Women's Clinic
OBSTETRICAL ASSESSMENT

NAME:	A/C #:

Please fill out the information below and bring it with you to the first visit.

Address:	Home Phone:
	Work Phone:
	Cell Phone:
Birthdate:	Occupation:
Is the Father of the baby involved?	Age:
Medication(s) now taking:	If yes, his name: Partner's work phone:
	Medication Allergies

FAMILY HISTORY(This information includes you, the baby's father, and both families who are blood relatives).	*Yes*	*No*
Is anyone of Italian, Greek, Mediterranean or Oriental descent?	_____	_____
Has anyone had a baby with a spinal cord defect?	_____	_____
Has anyone had a baby with Down Syndrome?	_____	_____
Any other genetic or chromosomal disorder in the family? If yes, what is the diagnosis? ______________________________	_____	_____
Has anyone had a baby with other forms of mental retardation? If yes, what is the diagnosis? ______________________________	_____	_____
Is anyone of Jewish descent or have you been told they have Tay-Sachs disease?	_____	_____
Any blood disorders such as sickle cell, hemophilia, or thalassemia?	_____	_____
Any history of Huntington's disease?	_____	_____
Any history of muscular dystrophy?	_____	_____
Any history of cystic fibrosis?	_____	_____
What other diseases run in your family? ______________________________		

PERSONAL HISTORY	*Yes*	*No*
Do you consider yourself at risk for HIV (AIDS)?	_______	_______
Do you live with someone with TB or have you ever been exposed to or tested positive for TB?	_______	_______
Have you or your partner ever had genital herpes?	_______	_______
Have you ever had any other sexually transmitted disease?	_______	_______
Do you empty a cat liter box?	_______	_______
Have you ever delivered a baby at 36 weeks or less?	_______	_______
Have you ever delivered a baby who weighed less than 5 lbs or more than 9 lbs?	_______	_______
Have you ever been pregnant with twins/triplets?	_______	_______
Have you ever had 2 or more miscarriages/abortions?	_______	_______
Have you ever been told you have an abnormal uterus?	_______	_______
Have you ever been told your cervix thinned or dilated at 32 weeks or less?	_______	_______
Have you ever had a cervical cerclage?	_______	_______
Have you ever had a cone biopsy, LEEP, laser or cryo of your cervix?	_______	_______

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	Yes	*No*
Have you ever been told you have too little or too much amniotic fluid?	_______	_____
Have you ever been diagnosed with high blood pressure when not pregnant?	_______	_____
Have you ever been diagnosed with high blood pressure when pregnant?	_______	_____
Have you ever had diabetes or gestational diabetes?	_______	_____
Have you ever had a blood clot (DVT or pulmonary embolus)?	_______	_____
Have you ever had an eating disorder?	_______	_____
Any history of treatment/medication for any psychiatric problems?	_______	_____
Have you ever had a kidney infection or kidney stones?	_______	_____
Any history of asthma or other breathing disorders?	_______	_____
Have you ever had hepatitis?	_______	_____
Have you ever had any complications from anesthesia?	_______	_____
Have you ever been told you are Rh sensitized?	_______	_____
Do you have a history of seizures?		

CURRENT PREGNANCY	_______	_____
Are you currently pregnant with twins/triplets?	_______	_____
Have you had any vaginal bleeding?	_______	_____
Have you had a temperature over 100.4?	_______	_____
Have you had a recent bladder or kidney infection?	_______	_____
Do you smoke? If so, how much? ____	_______	_____
Have you used any "street" drugs (such as marijuana, cocaine, amphetamines, sedatives, narcotics, etc.) If so, what drugs? ________________________________	_______	_____
Have you used any prescription or over-the-counter medications? If so, which ones? ____	_______	_____

Please sign here: ____ **Date:** _________________

Physician comments:

Signature/Date