DOCTORS EICHENLAUB AND MAY

OBSTETRICS & GYNECOLOGY

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Obstetrical Patient Registration

Personal Information:

Name Last_____First_____Middle_____

Father of Baby/ Partner Name_____

Address_____ City_____ Zip_____

Age_____ Birthdate_____ Social Security #_____

Phone (h)_____ (w)_____ (cell)_____

Occupation_____ Employer_____

Menstrual History:

LMP_____ Regular Cycles Y_____ N_____ Infertility Treatments Y____ N_____

Patient pre-pregnancy weight_____lbs. Height_____ft._____in.

At Home Pregnancy Test Month _____ Day_____ Date of last Pap Smear _____

Obstetrical History:

Please list all prior pregnancies :

N›. M/Year	Place	Weeks Gestation	Type of Del.	Sex	Weight	Anesthesia	Episiotomy
1.							
2.							
3.							
4.							
5.							
6.							
7.							

List all complications of prior pregnancies/deliveries:

_____

_____

Pregnancy History: Have you ever been diagnosed with any of the following? If Yes, please describe.

Tubal pregnancy	N	Y	_____
Pregnancy loss after 10 wks	N	Y	_____
Hypertension in pregnancy	N	Y	_____
Medication for hypertension	N	Y	_____
Diabetes (only in pregnancy)	N	Y	_____
Insulin dependent diabetes	N	Y	_____
Preterm labor requiring medication	N	Y	_____
Preterm delivery (before 37wks?)	N	Y	_____
Bleeding disorders requiring medication	N	Y	_____
Babies born with any birth defects	N	Y	_____
Babies with Down's/chromosomal defect	N	Y	_____
Twin preganacy	N	Y	_____
$Rh^{(-)}$ sensitivity	N	Y	_____

Patient's Medical History:

List Current Medications _____

Allergies to Medications_____

Allergies seasonal, foods, surgical dyes_____

Please ☐ if you have been diagnosed with any of the following? If Yes, please describe & list meds.

Neurological disorders:

Seizures _____

Migraine _____

Depression/Anxiety _____

Thyroid disorders _____

Cardiovascular: _____

Heart Murmur (MVP)____

Heart Defect _____

Hypertension _____

Cystic Fibrosis disease or trait ____

Asthma _____

Irritable Bowel Syndrome ____

Colitis _____

Gastric reflux disease _____

Pyleonephritis _____

Urinary Tract Infections ____

Sickle Cell Disease or trait _____

Bleeding disorders ____

Anemia _____

Breast mass/surgery/mastitis _____

Abnormal Pap Smear _____

Pelvic/Cervical Surgery ____

Genital Herpes ____

Human Papilloma Virus (HPV)_____

Chlamydia/Gonorrhea _____

HIV/AIDS _____

Hepatitis B or C _____

Patient Social History:

Married____ Single____ Separated____ Divorced____ Widowed_____

Smoke N____ Y____ pks/day_____

Drink Alcohol N_____ Y_____ Drinks/week _____

Abusive relationship N_____ Y_____ past history_____

Drug use during pregnancy N_____ Y_____ IV drug use history N_____ Y_____

Family History:

Please list what family members have been diagnosed with the following:

	Patients' Family	Father of the Baby	Father of the babys' family
Chromosomal birth defects			
Cardiac birth defects			
Cystic fibrosis disease/trait			
Seizure disorders			
Insulin dependent Diabetes			
Blood Clot disorder or stroke			
Sickle cell trait/disease			
Hemophilia/bleeding disorder			
Hepatitis B or C			
Sexually transmitted infection			
Jewish Decent/Tay Sach's			
Canavan's disease			
Twin/multiple births			