Miriam M. Yudkoff, M.D.
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www.womenobgyn.com

2003 Medical Parkway
Wayson Pavilion, Suite 250
Annapolis, MD 21401

PHONE: 410.224.2228
FAX: 410.266.7778

OBSTETRIC MEDICAL HISTORY

PLEASE ANSWER EVERY QUESTION (Use reverse side if needed) **FULL NAME** _____

PREFERRED NAME/NICKNAME: **OCCUPATION:** **AGE:** **BIRTH DATE:**

ADDRESS: **PHONE NUMBER:** **RACE:**

FATHER OF BABY NAME: **OCCUPATION:** **AGE:** **RACE:** **IS HE IN GOOD HEALTH?**

SOCIAL HISTORY Marital Status Years married/together Do you have cats? Y N
Packs/day CIGARETTES: ½ 1 2+ never quit/when? ALCOHOL never rarely weekly daily quit/when? CAFFEINE (cups/day) 0 1 2 3+

MEDICAL HISTORY CIRCLE IF YOU HAVE A PERSONAL HISTORY OF:
Cancer, Diabetes, High Blood Pressure, Seizures, DES Exposure, Blood Transfusion, Heart Murmur, Heart Disease, Migraine, Asthma, IBS
Abnormal Pap Smear, Thrombophlebitis, Deep Vein Thrombosis (DVT), frequent Urinary Tract Infection, Depression/Anxiety, Gastric Reflux,
Kidney Stones, Thyroid Disease, Chlamydia, Gonorrhea, Venereal Warts, Hepatitis, HIV/AIDs, Genital or Oral Herpes (you or partner)
ANY OTHER MEDICAL CONDITION? YES NO List if Yes: NONE OF THE ABOVE

List all ALLERGIES and reaction (nausea, hives, etc.) NO ALLERGIES

List all current MEDICATIONS and doses include vitamins, calcium, herbs and nonprescription meds. NO MEDS

List all SURGERIES and dates NO SURGERIES

FAMILY HISTORY Parents and Siblings Alive and Well? Yes No If deceased, list cause
Circle if any family history of: Diabetes, Heart Attacks Thrombophlebitis, Cancer, Death from anesthesia, Bleeding disorder, Stroke,
High Blood Pressure, Osteoporosis, Birth Defect, Intellectual Disability, Twins, Lethal Blood Clot YES NO Who:

REVIEW OF SYSTEMS: Circle any CURRENT significant or unexplained symptoms
Cough, Sore Throat, Chest pain, shortness of breath, Heart palpitations, Visual changes, Unexplained weight change, Fevers, Nausea, Vomiting,
Change in bowels, Abnormal vaginal bleeding, Abdominal pain, Urinary pain, Frequent urination, significant urinary Leakage,
Severe or frequent Headaches, Muscle Weakness, Depression/Anxiety, Night Sweats, Rashes, Joint swelling NONE OF THE ABOVE
List any other significant symptoms:

Physician Signature **Today's Date (MM/DD/YYYY)**

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FULL NAME _____

MENSTRUAL HISTORY Last menstrual period (1st day) Normal? Yes No Previous period Prepregnancy weight
Age of first period How frequently do they come? How many days do they last? FLOW: Heavy Medium Light
Bad Cramps? Yes No Bleeding in between? Yes No Abnormal discharge Yes No Date of last pap smear
Problems Conceiving? Positive Pregnancy Test? Where? Date

Any Bleeding since last menses? Describe if Yes

OB HISTORY: Fill in chart, including all deliveries, miscarriages and abortions

Date:					
Hospital/Doctor					
Weeks gestation (40 weeks is due date)					
Hours in labor					
Anesthesia (none, narcotic, epidural, general, spinal					
Delivery route (vaginal. C-Sec Forcep, vacuum, D&C)					
Complications (Bleeding, diabetes, preeclampsia, hypertension, etc.)					
Sex (F or M) and name of baby					
Weight of baby					
Apgars/Current Health					

PHYSICAL EXAM by M.D. BP: / Pulse Height Weight

General: WDWNNAD Thyroid: Nonpalpable Neck: Supple, no adenopathy Skin: w/o rash Heart: RR, no murmur Lungs: Clear nl resp effort
Breasts: No masses palpated, no skin thickening or retraction, no axillary adenopathy Extremities: No ankel edema, no clubbing of nails
Abdomen: Soft, Flat, NT, no hepatosplenomegaly, no umbilical or inguinal hernias Vulva: NL BSU, NL perineal body
Vagina: Clear, No abn d/c, support NL Cervix: Clear, d/c nl, long and closed Adenexae: NT, no palpable masses
Rectum: Sphincter NL, no masses Uterus: Exam abnormals:

Physician Signature **Today's Date (MM/DD/YYYY)**