Women's Health For Life, Inc.
1005 Bellefontaine Ave., Suite 175
Lima, OH 45804
Phone (419) 227-2727
Fax (419) 227-2737
www.womenshealthforlife.com

770 West High Street, Suite 400
Lima, OH 45801

OBSTETRICAL INFORMATION SHEET

Name	Age	Today's Date
		/ /

Date of Birth	Marital Status	Occupation
/ /		

Last Grade Completed	Family Practitioner	Insurance

Date of Last Menstrual Period	How often are periods & days long?	Was pregnancy planned?	Were you on birth control?
/ /		Yes / No	Yes / No

PAST PREGNANCIES

Date	Weeks	Length of Labor	Weight	Delivery Type	Where Delivered	Complications
/ /						
/ /						
/ /						
/ /						
/ /						

PAST MEDICAL HISTORY

	Yes	No		Yes	No
Sugar Diabetes			Infertility		
High Blood Pressure			Blood Transfusions		
Heart Problems			Mother Exposed to DES		
Heart Valve Problems			Rh Sensitization (Rhogam)		
Kidney Disease or Infections			Tuberculosis		
Neurologic/Seizures			Lung Problems – Asthma		
Depression/Mental Problems			Anesthetic Complications		
Hepatitis/Liver Disease			History of an Abnormal Pap		
Leg Vein Problems			Uterine Abnormality		
Thyroid Problems			Major Accident		

Have you, the baby's father or anyone in either family had:
Thalassemia, neural tube defects, downs syndrome, tay-sachs disease, sickle cell, hemophilia, muscular dystrophy, cystic fibrosis, huntington's chorea, mental retardation, inherited chromosomal defects, or babies born with birth defects? If so indicate whom.

Do you or your partner have genital herpes?

Have you had a rash or illness since your last menstrual period?

Have you ever had a sexually transmitted disease (gonorrhea, chlamydia, condyloma, trichomonas or syphilllis)?

Details of yes answers:

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SURGICAL HISTORY

Year	Operation	City	Surgeon	Complicaitons

Current Medications:

Allergies & Reactions:

Cigarette Smoking:

Alcohol Consumption:

Drug or Marijuana Usage:

FAMILY MEDICAL HISTORY

Father	
Mother	
Siblings	
Children	
Grandparents	
Aunts/Uncles	
Cousins	

CURRENT MEDICAL HISTORY

Please circle if you have any of the following:
Weight changes, appetite changes, unusual weakness, bleeding, chills, fevers, recent accidents or infections. Vision changes, hearing changes, bloody noses, unusual sneezing, sore throat, swallowing difficulties, ear pain or face pain. Neck pain, swelling or stiffness. Cough, difficulty breathing or coughing up blood. Chest pain or chest fluttering. Abdominal pain, sickness to stomach, throwing up, diarrhea, constipation or problems with stools. Difficulty with urination. Joint stiffness, back pain, muscle cramps. Rash, skin lesions, easy bruising or itching. Memory loss, dizziness, double vision, clumsiness or headaches

Other issues to bring to the attention of our staff:

THANK YOU

Signature	Parent or Guardian Signature (if Minor)
Date	Witness