Obstetrical History Form (For patients with a positive pregnancy test)

Family Name: ______________________

Given Name(s): ______________________

First day of last period: 20____/____/______ or unknown

Expected date of delivery (if known): 20____/____/______

Fertility treatments: ☐No
☐Yes (Hospital name: ________________)
☐Timing method ☐Ovulation induction ☐AIH
☐IVF (in vitro fertilization)
☐Fresh embryo transfer
☐Frozen embryo transfer (egg retrieval date: ____/____/____)
☐Pregnancy through egg donation

☐Positive pregnancy test date: 20____/____/______

☐Confirmed pregnancy at a hospital: 20____/____/______
(Hospital name: or Aiiku Hospital)

Menstrual History

Cycle length: ~____days Duration of bleeding:____days

Interval: ☐Regular ☐Irregular

Menstrual flow: ☐Light ☐Moderate ☐Heavy

Menstrual complications: ☐No ☐Yes: ______________

Age at first period: ________ years old

Height: ________cm Usual Weight: ________kg

Pregnancy History: Past Pregnancies: ______times Delivery: _______times Miscarriages: _______times (Ectopic Pregnancies: _______times)
Abortions: _______times Stillbirths: _______times

#	Delivery Date Year / Month / Day	Weeks	Sex	Baby's Birth Weight	Baby's Outcome	Type of Delivery	Induction of Labor	Newborn Complications	Place of Delivery	Remarks
1	_____/_____/_____		M / F	g	☐Alive ☐Died	☐Vaginal ☐Cesarean Section ☐Vacuum/Forceps	☐Yes ☐No			
2	_____/_____/_____		M / F	g	☐Alive ☐Died	☐Vaginal ☐Cesarean Section ☐Vacuum/Forceps	☐Yes ☐No			
3	_____/_____/_____		M / F	g	☐Alive ☐Died	☐Vaginal ☐Cesarean Section ☐Vacuum/Forceps	☐Yes ☐No			
4	_____/_____/_____		M / F	g	☐Alive ☐Died	☐Vaginal ☐Cesarean Section ☐Vacuum/Forceps	☐Yes ☐No			

Any pregnancy-related complications in the past:
☐High blood pressure ☐HELLP Syndrome ☐Seizures ☐Massive bleeding ☐Placenta abnormalities ☐Gestational Diabetes ☐Other:____________________

Marital Status

☐Married Age at marriage: ____ years old
☐Divorced ☐Widowed ☐Remarried

☐Not married Marriage plans: ☐Yes ☐No
Other ( )

Do you currently smoke?
☐No ☐Secondhand smoke ☐Yes (______cigarettes/day)

Did you smoke before this pregnancy?
☐No ☐Secondhand smoke ☐Yes (______cigarettes/day)

Do you currently drink alcohol?
☐No ☐Socially ☐Almost everyday (_______mL/day)

Family History

Diabetes: ☐No ☐Yes (who: __________________)

High blood pressure: ☐No ☐Yes (who: ___________)

Other (genetic, blood, etc.): ______________________

Current medications: ___________________________

Referral Letter ☐No ☐Yes

Place of Delivery ☐Aiiku Hospital (at Tamachi)
☐Other: ________________ ☐Not decided

Cervical cancer checkup (Pap smear) within 1 year
☐No ☐Yes; result: ☐Normal ☐Abnormal

Have you ever had any of the conditions/disorders listed below?

Past Medical History: ☐No ☐Yes	Please give details (diagnosis, hospitalizations, surgeries, etc.) about the items you checked in the left column.
☐ Central nervous system (including cerebral vascular diseases – blood vessels in the brain) ☐ Respiratory disease (☐Pneumonia ☐Bronchitis ☐Asthma – Last episode: _______ years old) ☐ Gastrointestinal disease (☐Appendicitis) ☐ Liver disease (☐Hepatitis) ☐ Kidney / Urological disease (☐Nephritis ☐Pyelonephritis ☐Bladder inflammation) ☐ Blood disease (☐Thalassemia) ☐ Heart disease (☐Abnormal EKG ☐Arrhythmia) ☐ Thyroid disease (☐Hyperthyroidism ☐Hypothyroidism ☐Chronic thyroiditis (Hashimoto Disease) ☐ Bone disease ☐ Muscle disease ☐ Uterine disease (☐Uterine malformation ☐Uterine fibroids ☐Other) ☐ Disease of the ovaries and fallopian tubes (☐Ovarian cyst ☐Blocked / fluid-filled fallopian tube) ☐ External injury / poisoning ☐ Blood group incompatibility ☐ Autoimmune disease ☐ Essential hypertension (idiopathic hypertension) ☐ Diabetes ☐ Psychiatric / Mental disorder (☐Panic disorder ☐Bipolar disorder ☐Eating disorder ☐Other) ☐ Other	

Have you had any of the following complications during pregnancy or delivery?

Obstetrical History: ☐No ☐Yes	Please give details about the items you checked in the left column.
☐ Threatened miscarriage ☐ Shortened cervix ☐ Placental abruption ☐ Pregnancy-induced hypertension ☐ Fetal growth restriction ☐ Sexually transmitted infections ☐ Other ☐ Vaginal bleeding during pregnancy ☐ Cervical laceration ☐ Cervical surgery (LEEP) ☐ Preeclampsia ☐ Placenta previa (low-lying) ☐ Gestational diabetes ☐ Preterm labor ☐ Incompetent cervix ☐ Cervical surgery (cone biopsy) ☐ Premature rupture of membranes (before 37 weeks) ☐ Pulmonary embolism (blood clot in the lung) ☐ Stillbirth	