CHEAHA WOMEN'S HEALTH AND WELLNESS
Joshua Johannson M.D., FACOG – Obstetrics and Gynecology
office # 256-241-0885 – www.cheahawomen.com

NEW OB HISTORY FORM

Patient's Name: _____ DOB: _____
Date form completed: _____

Last Menstrual Period: _____
Name of Infant's Father: _____ Phone Number: _____
Husband/ Domestic Partner: _____ Phone Number: _____
Pediatrician: _____ Phone Number: _____

Genetic Screening and Infection History

** Please circle answer below, if yes please explain. If no to all please check below**
No to all: __

Patient's age will be 35 years or older at estimated delivery date- Yes or No	Other Inherited Genetic or Chromosomal Disorder-Yes or No
Thalassemia (Italian, Greek, Mediterranean, or Asian background: MCV < 80- Yes or No	Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)Yes or No
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)- Yes or No	Patient or Baby's Father had a child with birth defects not listed above- Yes or No
Congenital Heart Defect- Yes or No	Recurrent Pregnancy Loss, or a stillbirth- Yes or No
Down syndrome- Yes or No	Medications (including Supplements, Vitamins, Herbs, OTC Drugs) Illicit/ Recreational Drugs, Alcohol- Yes or No
Tay-Sachs (eg, Jewish, Cajun, French Canadian- Yes or No	If yes, Agent(s) and Strength/Dosage-
Canavan Disease- Yes or No	Any other Genetic History- Yes or No
Sickle Cell Disease or Trait (African)- Yes or No	Live with someone with TB or exposed to TB- Yes or No
Hemophilia or other Blood Disorders- Yes or No	Patient or Partner has history of Genital Herpes-Yes or No
Muscular Dystrophy- Yes or No	Rash or Viral Illness since last menstrual period- Yes or No
Cystic Fibrosis- Yes or No	History or STD, Gonorrhea, Chlamydia, HPV, Syphilis- Yes or No
Huntington's Chorea- Yes or No	Other Infection History- Yes or No
Mental Retardation- Yes or No	If yes, was person tested for fragile X? Yes or No

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PAST PREGNANCY HISTORY

Have you ever had any of the following? Please circle all that apply

Gestational Diabetes Preeclampsia/Toxemia C- Section: How many ____

Pre-Term Delivery Stillbirth: How many ___

Other delivery complications: _____

_____

_____

Patient's Signature: _____

Reviewed by: _____