

Patient Name _____ D.O.B. _____

OB Flowsheet History

Problem	Yes / No	Comment
Diabetes	Yes / No	
Heart Disease	Yes / No	
Hypertension	Yes / No	
Kidney disease/UTI	Yes / No	
GI Disorders	Yes / No	
Hepatitis/Liver Disease	Yes / No	
Pulmonary (TB, Asthma)	Yes / No	
Neurologic/Epilepsy	Yes / No	
Autoimmune Disorder	Yes / No	
Vascular/Thromboembolic	Yes / No	
Varicosities/Phlebitis	Yes / No	
History of blood transfusion	Yes / No	
Anemia	Yes / No	
Thyroid Dysfunction	Yes / No	
Depression/Post Partum Depression	Yes / No	
Trauma/Violence	Yes / No	
Tobacco	Yes / No	
Alcohol	Yes / No	
Illicit/Recreational drugs	Yes / No	
D (Rh) sensitivity	Yes / No	
Seasonal Allergies	Yes / No	
Drug/latex allergies	Yes / No	
Breast	Yes / No	
GYN surgery	Yes / No	
Operations/hospitalization	Yes / No	
Anesthetic complications	Yes / No	
History of abnormal pap	Yes / No	
Uterine anomaly/DES	Yes / No	
Infertility	Yes / No	
Rheumatic Fever	Yes / No	
Relevant Family History	Yes / No	
HIV	Yes / No	
Other	Yes / No	

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Genetic Screening and Infection History

Problem	Yes / No	Problem	Yes / No
Age > 35 at time of delivery	Yes / No	Rash or viral illness since last menstrual period	Yes / No
Recurrent pregnancy loss or stillbirth	Yes / No	Live with someone with TB or exposed to TB	Yes / No
Downs syndrome	Yes / No	Genital herpes (patient or partner)	Yes / No
Thalassemia	Yes / No	History of STD (gonorrhea, Chlamydia, HPV or syphilis)	Yes / No
Sickle Cell disease or trait	Yes / No	Hepatitis	Yes / No
Hemophilia or other blood disorders	Yes / No	HIV	Yes / No
Congenital heart defect	Yes / No	Chickenpox or Mumps	Yes / No
Neural Tube Defect	Yes / No	Rubella/Measles	Yes / No
Tay-Sachs	Yes / No	Toxoplasmosis (do you change cat litter?)	Yes / No
Muscular Dystrophy	Yes / No	Group B Strep	Yes / No
Canavan Disease	Yes / No	Comments:	
Cystic Fibrosis	Yes / No		
Mental Retardation/Autism	Yes / No		
If yes, was person tested for fragile X	Yes / No		
Other inherited genetic or chromosomal disorder	Yes / No		
Patient or baby's father had a child with birth defects not listed	Yes / No		
Medications/illicit/recreational drugs/alcohol since last menstrual period	Yes / No		