WOMEN PARTNERS
IN OB/GYN

Name: **Date:**

NEW OB HISTORY

GENETIC TESTING: Please check if you, the father of the baby, a first degree relative or any babies born in your family have had any of following:

	Yes	No	Please list who:
Cystic Fibrosis			
Down Syndrome/ Mental retardation/ Fragile X			
Heart defects			
Hemophilia/ Bleeding disorder			
Huntington chorea			
Muscular dystrophy			
Neural tube defects (spina bifida, anencephaly)			
Sickle Cell			
Thalassemia			
Tay Sachs			
Other birth defects or chromosomal abnormalities:			

PREGNANCY INFORMATION:

Were you using any birth control when you became pregnant? Yes No

Date of home urine pregnancy test_____

Do you have a history of herpes? Yes No

Have you had MRSA? Yes No

What is your pre-pregnancy weight _____

What is your ethnicity? _____

Do you have a cat? Yes No Have you had chickenpox? Yes No

Do you plan to take childbirth classes? Yes No

Do you plan to have an epidural in labor? Yes No

If you've had a cesarean section, do you want a repeat c-section? Yes No

Do you want your tubes tied after the birth of this baby? Yes No

Do you plan to breastfeed? Yes No

If you have a son, do you want him circumcised? Yes No

Do you have a pediatrician? Yes No Do you have an infant car seat? Yes No

What do you plan to use for contraception after the birth of your baby?

Condoms	IUD
Birth control pills	Tubal ligation
Ortho Evra patch	Vasectomy
Nuvaring	Nothing
Other	Undecided