OBGYN Care Visit

Today's Date: _____

This worksheet is designed to help you and your health care provider determine your pregnancy care needs.

Personal Information:

Name: _____
Last First Middle Preferred Name

_____
Gender Identity (e.g. female, transgender male) Pronouns (eg. she/her, they/them) Sexual Orientation (e.g. straight, homosexual, bisexual)

Birthdate: _____ Preferred Language: _____

Highest level of education: _____ Occupation: _____

Phone Number: _____ Ethnic Background: _____

DOD ID#: _____ Active Duty ☐ or Beneficiary ☐

Pregnancy Timing:

There are several options in pregnancy. Are you considering:

☐ continuing the pregnancy with intention to parent
☐ continuing the pregnancy with intention of adoption
☐ abortion
☐ other (surrogacy, etc)

If you could change the timing of this pregnancy, would you want it:

☐ earlier
☐ later
☐ not at all
☐ N/A (I would not change the timing.)

Do you expect a change in duty station, change in insurance or spouse deployment during this pregnancy?
☐ yes ☐ no If yes, explain: _____

Pregnancy Dating:

What was the first day of your last menstrual period? _____(dd/mm/yyyy)
Are you sure of this date? ☐ yes ☐ no
Was your last period normal? ☐ yes ☐ no
Are your periods regular? ☐ yes ☐ no
If no, how many days from the beginning of one period to the beginning of the next?_____
Have you had any ultrasounds that measured the due date outside this facility before today?_____
If so, when?_____ Where?_____ Due Date given?_____
Were you taking birth control or had a birth control implant (e.g. intrauterine device/IUD or Nexplanon) when you became pregnant? ☐ yes ☐ no If taking birth control pills, when did you stop? _____
Were you breastfeeding at the time of conception? ☐ yes ☐ no

Is this pregnancy from IVF (in vitro fertilization)? ☐ yes ☐ no

If so, what was the IVF transfer date? _____ Was it a 3 or 5 day embryo?_____

What due date the the IVF provider give you? _____

Personal Health History:

Have you ever had an allergic reaction to: If yes, please list the allergy and describe the reaction:
(e.g. itching, rash, hives, anaphylaxis [throat closing up], etc)

Penicillin/Amoxicillin? ☐ yes ☐ no
A medication or vaccine? ☐ yes ☐ no
Shellfish/Iodine? ☐ yes ☐ no
Latex? ☐ yes ☐ no

Other:_____

Please mark any condition that you have or have had in the past:

☐ Anemia	☐ Frequent infections	☐ Psychiatric/Mental Illness
☐ Anxiety	☐ Gestational Diabetes	☐ Pulmonary Embolism
☐ Arthritis or Lupus	☐ Group B Strep prior pregnancy	☐ Pneumonia
☐ Asthma	☐ Irritable Bowel Syndrome	☐ Recurrent Urinary Infections (>3/yr)
☐ Blood clotting disorder	☐ Heart Disease/Murmur	☐ Sexually Transmitted infections
☐ Breast Disease	☐ High Blood Pressure	☐ Sickle Cell/Thalassemia
☐ Cancer	☐ Gestational Hypertension	☐ Skin Disorder
☐ Celiac Disease	☐ Preeclampsia	☐ Thyroid disorder
☐ Crohn's Disease	☐ Kidney Disorder	☐ Von Willebrand/bleeding disorder
☐ Depression	☐ Migraines	☐ Anesthesia problems
☐ Diabetes (Type 1 or 2)	☐ Pyelonephritis/kidney infection	☐ Sleep Disorder (e.g. apnea, narcolepsy)
☐ Ectopic Pregnancy	☐ Prior preterm birth (<37wk)	☐ Other:

Describe if needed:

Gynecologic Health History:

When was your last test for cervical cancer (e.g. pap)? _____

Have you ever had an abnormal pap or other cervical cancer test? ☐ yes ☐ no

If yes, when? _____ What was the diagnosis? _____

How were you treated? _____

_____

Have you ever had any of the following: If yes, when, on what body part, and how were you treated?

☐ HPV
☐ Genital Warts
☐ Chlamydia
☐ Gonorrhea
☐ Genital Herpes
☐ Syphilis

Infection/Immunization History:

Have you had an influenza vaccine this year? ☐ yes ☐ no If yes, when? _____

Have you had any COVID vaccines? ☐ yes ☐ no How many doses/when? _____

Have you had any HPV (human papilloma virus) vaccines as an adolescent or adult? ☐ yes ☐ no

If yes, how many doses did you receive? _____ When? _____

Please mark any condition/infection that you have or have had in the past:

☐ HIV/AIDS ☐ Hepatitis ☐ MRSA ☐ Tuberculosis

Past Procedure/Surgical History:

Cesarean	☐ yes	☐ no	Cervical LEEP	☐ yes	☐ no
Conization of Cervix	☐ yes	☐ no	Uterine Surgery	☐ yes	☐ no
Cervical Cryocauterization	☐ yes	☐ no	Breast Surgery	☐ yes	☐ no
Colposcopy	☐ yes	☐ no	Blood Transfusion	☐ yes	☐ no
Gynecological Surgery	☐ yes	☐ no			

Other surgeries: (e.g. appendectomy, tonsillectomy, bone fracture repair, gall bladder removal, etc):

Exposures Affecting Health:

Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system, or vaped? ☐ yes ☐ no If yes, how many packs/cigarettes/cartridges per day? _____

If former smoker, when did you quit? _____

Do you currently or have you in the past year smoked, vaped, dabbed, or eaten marijuana? ☐ yes ☐ no

If yes, how are you using it and how often? _____

If former marijuana user, how and when did you quit? _____

Do you drink alcoholic beverages now or did you before you became pregnant? ☐ yes ☐ no

If yes, please indicate number of drinks and type per week: _____

List any medications taken since your last period (including prescriptions, supplements, OTC, vitamins, herbals):

_____

Have you used any non-prescription recreational drugs since your LMP (e.g. cocaine, opioids, meth, ecstasy)?

☐ yes ☐ no If yes, what kind and how often? _____

Have you been exposed to chemicals (pesticides, lead, hazardous materials, or radiation) since your LMP?

☐ yes ☐ no If yes, what kind and how often? _____

Do you have any dietary restrictions? ☐ yes ☐ no If yes, describe?

_____

Pregnancy History:

Have you ever been pregnant before? ☐ yes ☐ no If no, skip to next section.

How many pregnancies have you had including this current pregnancy? _____

In chronological order in the chart below, list your pregnancies and include the following information:

- Month and year of delivery or abortion/termination/miscarriage
- How many weeks pregnant you were when you delivered/terminated/miscarried (40weeks is the due date)
- Type of delivery (vaginal, cesarean, vacuum assisted, forceps assisted, D&C, medication abortion)
- Anesthesia for the delivery, if any (IV meds, local numbing, epidural, spinal, general)
- Pregnancy complications, such as:
    - growth restriction (IUGR)
    - gestational diabetes (GDM)
    - birth defect
    - preeclampsia
    - placenta abruption
    - cholestasis (ICP)
    - postpartum fever/infection
    - postpartum depression
    - blood transfusion
    - cervical incompetence requiring cerclage
    - rupture of membranes prior to 37 weeks (PPROM)
    - spontaneous delivery prior to 37 weeks (preterm birth)
    - gestational hypertension (GHTN)
    - placenta previa (overlying cervix)
    - DVT or PE (pulmonary embolus) (blood clot in leg or lung)
    - infection/fever during labor (chorio)
    - postpartum readmission
    - postpartum hemorrhage (PPH) (too much blood loss)
    - 3rd degree laceration (into the anal sphincter muscle)
    - 4th degree laceration (through the anal sphincter muscle into the rectum)
    - miscarriage (< 12 weeks)
    - miscarriage after 12 weeks
    - fetal loss after 20 weeks
    - ectopic (pregnancy outside the uterus often in the tubes)

Date	Weeks Gestation	Type of Delivery	Anesthesia	Complications

Family History & Genetic Screening:

Does *this baby* have any genetic relatives with a history of the following? (if yes, list how this person related):

Thalassemia	☐ yes	☐ no	_____
Neural tube defect (spina bifida)	☐ yes	☐ no	_____
Congenital Heart Defect	☐ yes	☐ no	_____
Down Syndrome	☐ yes	☐ no	_____
Tay-Sachs	☐ yes	☐ no	_____
Sickle Cell Disease	☐ yes	☐ no	_____
Hemophilia	☐ yes	☐ no	_____
Muscular Dystrophy	☐ yes	☐ no	_____
Cystic Fibrosis	☐ yes	☐ no	_____
Huntington's Chorea	☐ yes	☐ no	_____
Mental Retardation	☐ yes	☐ no	_____
Autism	☐ yes	☐ no	_____
Fragile X	☐ yes	☐ no	_____
Metabolic Disorder	☐ yes	☐ no	_____
Birth Defects	☐ yes	☐ no	_____
Recurrent (>3) Miscarriages	☐ yes	☐ no	_____
Stillbirth	☐ yes	☐ no	_____
Other Inherited Disorder	☐ yes	☐ no	_____

Would you like Cystic Fibrosis carrier test? ☐ yes ☐ no ☐ more information/unsure

Do *you* have any 1st or 2nd degree relatives with a medical history of any of the following? (mother, father, brother, sister, maternal grandparent [mom's mom or dad], or paternal grandparent [dad's mom or dad]):

Breast cancer diagnosed prior to menopause	☐ yes	☐ no	_____
Ovarian cancer	☐ yes	☐ no	_____
Diabetes	☐ yes	☐ no	_____
Bleeding or blood clotting disorder	☐ yes	☐ no	_____
Unexplained stroke at a young age	☐ yes	☐ no	_____

Mother/Sisters with pre-eclampsia or eclampsia ☐ yes ☐ no _____

Additional family history: _____

_____

Partner Information:

Name_____ Phone number: _____

Relationship_____ Do they live with you? ☐ yes ☐ no If no, where? _____

Planning to be involved with your care ☐ yes ☐ no Involved with parenting? ☐ yes ☐ no

Do/will they have any problems with getting access to Fort Carson? ☐ yes ☐ no