



DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

317 N. El Camino Real, Suite 101
 Encinitas, CA 92024
 (760) 944-1000 • FAX (760) 944-1123

FINAL EDD _____

BIRTH DATE	AGE	RACE	MARITAL STATUS	ADDRESS	
MO DAY YR			S M W D SEP	ZIP:	PHONE: (H) (O)
OCCUPATION <input type="checkbox"/> HOMEMAKER <input type="checkbox"/> OUTSIDE WORK <input type="checkbox"/> STUDENT <small>Type of Work</small>			EDUCATION (LAST GRADE COMPLETED)		INSURANCE CARRIER/MEDICAID #
HUSBAND/FATHER OF BABY:			PHONE	EMERGENCY CONTACT: PHONE	
TOTAL PREG.	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	ECTOPICS
					MULTIPLE BIRTHS
					LIVING

MENSTRUAL HISTORY

LMP DEFINITE APPROXIMATE (MONTH KNOWN) UNKNOWN NORMAL AMOUNT/DURATION FINAL _____

MENSES MONTHLY YES NO FREQUENCY: Q _____ DAYS MENARCHE _____ (AGE ONSET)

PRIOR MENSES _____ DATE ON BCPs AT CONCEPT. YES NO hCG + ____/____/____

PAST PREGNANCIES (LAST SIX)

DATE MO / YR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES / NO	COMMENTS/ COMPLICATIONS

PAST MEDICAL HISTORY

	0 Neg + Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT	0 Neg + Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES				16. D (Rh) SENSITIZED
2. HYPERTENSION			17. PULMONARY (TB, ASTHMA)	
3. HEART DISEASE			18. ALLERGIES (DRUGS)	
4. AUTOIMMUNE DISORDER			19. BREAST	
5. KIDNEY DISEASE/UTI			20. GYN SURGERY	
6. NEUROLOGIC/EPILEPSY			21. OPERATIONS/HOSPITALIZATIONS (YEAR & REASON)	
7. PSYCHIATRIC				
8. HEPATITIS/LIVER DISEASE				
9. VARICOSITIES/PHLEBITIS				
10. THYROID DYSFUNCTION			22. ANESTHETIC COMPLICATIONS	
11. TRAUMA/VIOLENCE			23. HISTORY OF ABNORMAL PAP	
12. HISTORY OF BLOOD TRANSFUS.			24. UTERINE ANOMALY/DES	
	AMT/DAY PREPREG	AMT/DAY PREG	# YRS USE	25. INFERTILITY
13. TOBACCO				26. RELEVANT FAMILY HISTORY
14. ALCOHOL				27. OTHER
15. STREET DRUGS				

COMMENTS: _____

