Antepartum Medical History Questionnaire

Date: ________________
Name: _______________________________
Birthdate: ______________
Marital Status: S M W D
Address: ______________________________
____
Email: ________________________________

Husband/Domestic Partner:
_______________________________________ Phone: ______________________________
Father of Baby:
_______________________________________ Phone: ______________________________
Emergency Contact:
_______________________________________ Phone: ______________________________

LMP: (first day) _______________ Menses Monthly? Yes No

Frequency: Every _____ days Menarche: (age of onset) _____________

Were you on birth control at time of conception? Yes No

All Past Pregnancies

Date of Delivery: ___________ Weeks Gestation: _____ Length of Labor: _____ Hours

Birth Weight: ______________ Sex: M F Preterm Labor: Yes No

Gestational Diabetes? Yes No Preg. Induced Hypertension? Yes No

GBS (group bacteria strep): Positive Negative Unknown

Type of Delivery: Vaginal C-section Anesthesia: Yes (type) _______________ No

Place of Delivery: ______________________________________

Comments/Complications:

____

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