**Texas Perinatal Group**
**911 W. 38th Street, Suite #201**
**Austin, Texas 78705**
**(512) 459-1131**

**Date:** ______________________

**Patient Name:** ____________________________________________ **DOB:** ________________

**Age:** _______ **Height:** ________ **Pre Pregnancy Weight:** ________

**Obstetric History Questionnaire**

**Please list your pregnancy history and outcomes in the table below (including miscarriages/abortions/ectopic):**

| Year | Weeks | Birth LB. / OZ. | Miscarriage/ Abortion | Type Of Delivery | Complications |
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**Please list current medications (including over the counter, vitamin and herbal supplements):**

| Medications Taken | Dose |
|---|---|
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**Pharmacy Contact Information:**

**Name:** ____________________________________________ **Phone #:** ___________________________

**Drug Allergies:** ______________________________________________________________________________