Patient Name: ___________________________________
Social Security Number: ____________________
Date: ___________________

Obstetric History Questionnaire

Are you currently pregnant: ☐ Yes ☐ No

What was the first day of your last menstrual period: _______________

What is your due date: __________________

Are there any problems with your current pregnancy:

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Prior Pregnancies:

________ **Number of pregnancies continued past 4 ½ months (20 weeks)**

________ **Number of miscarriages**

________ **Number of tubal pregnancies (ectopic pregnancies)**

________ **Number of abortions**

________ **Number of living children**

Fill information in table below for each pregnancy start with your first one:

Year	Weeks	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery	Anesthesia	Hospital and Doctor

OBSTETRIX MEDICAL GROUP

Total Pregnancies	Full Term	Premature	Abortion Induced	Miscarriages	Ectopics	Multiple Births	Living Children

Comments: ____

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Reviewed By ______________________________

Provider Name