

ULTRASOUND ASSOCIATES

Women's Imaging Center

OBSTETRICAL HISTORY FORM

FIRST NAME _____ LAST NAME _____

AGE _____ DATE OF LAST MENSTRUAL PERIOD _____

POSTIVE PREGNANCY TEST? _____ HOME TEST? _____ BLOOD TEST? _____

REASON YOUR DOCTOR ORDERED EXAM:

WHAT ARE YOUR SYMPTOMS?

TOTAL NUMBER OF PREGNANCIES _____
(Including this one)

MISCARRIAGES? _____
ABORTIONS? _____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

NAUSEA/VOMITING Y OR N BACK PAIN Y OR N

ABDOMINAL PAIN OR PELVIC PRESSURE Y OR N BLEEDING Y OR N

CRAMPING Y OR N

DO YOU HAVE HISTORY OF?

PREMATURE DELIVERY Y OR N PREVIOUS C-SECTION Y OR N

ECTOPIC PREGNANCY Y OR N LEEP PROCEDURE Y OR N

ABNORMAL PAP SMEAR? Y OR N

PREVIOUS BIRTH DEFECT OR ABNORMALITY Y OR N SPECIFY _____

DO YOU HAVE?

HYPERTENSION (HTN) Y OR N

DIABETES Y OR N

INSULIN DEPENDENT Y OR N

ARE YOU CURRENTLY TAKING MEDICATION? Y OR N TYPE _____

DO YOU HAVE ANY CONCERNS OR WORRIES WITH THIS PREGNANCY? _____
