Stanford HEALTH CARE

Los Olivos Women's Medical Group

Name: ______________________________ Date: ______________

Partner's name: ______________________ His contact phone: ______________

First day of last menses:____________Due date: __________ Weeks pregnant: _____

Number of Pregnancies: ________ Full Term Deliveries: _______ Preterm Deliveries: ______

Miscarriages: _________ Pregnancy terminations: _________ Ectopic Pregnancies: _____

Did you complete the portal questionnaire? YES NO

Did you complete the portal genetics history? YES NO

Do you consider this pregnancy to be high risk? YES NO If yes, why? ______________

____

____

Have you had any problems during this pregnancy? YES NO Is yes, what? ______________

____

Previous Pregnancy History: Twins (complete baby info in following section and label twin).

Baby #1

Date of delivery:__________Gender:_________Name of baby: ______________

Birth Weight:_________Completed weeks of pregnancy:___Anesthesia: ______________

Hospital, City, Delivering Physician: ______________

Problems during the Pregnancy: ______________

Problems during Delivery: ______________

Vaginal, Cesarean, Vacuum or Forceps: ______________

Comments: ______________

Baby #2

Date of delivery:__________Gender:_________Name of baby: ______________

Birth Weight:_________Completed weeks of pregnancy:___Anesthesia: ______________

Hospital, City, Delivering Physician: ______________

Problems during the Pregnancy: ______________

Problems during Delivery: ______________

Vaginal, Cesarean, Vacuum or Forceps: ______________

Comments: ______________

Baby #3

Date of delivery:__________Gender:_________Name of baby: ______________

Birth Weight:_________Completed weeks of pregnancy:___Anesthesia: ______________

Hospital, City, And Delivering Physician: ______________

Problems during the Pregnancy: ______________

Problems during Delivery: ______________

Vaginal, Cesarean, Vacuum or Forceps: ______________

Comments: ______________