UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Obstetrics & Gynecology
Maternal-Fetal Medicine at
Children's Medical Center Legacy

Medical Information

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SSN: XXX-XX-___ ___ ___ ___ SEX:_____
DOS: _____

Name: _____ Age: _____ Date: _____

Reason for visit: _____

_____

Referred by: _____

Date of last period: _____ Due Date: _____

Pregnancies: _____ # Children: _____ # Miscarriages: _____ # Ectopics: _____

Year	Gender	Weight	Vaginal or Cesarean	Gest. Age	Complication

Operations	Year	Other Hospitalizations	Year

Drug allergies: _____

Present medications: _____

	No	Yes
Are your vaccinations up to date (influenza, hepatitis, tetanus, rubella)?	☐	☐
Have you had an ultrasound exam this pregnancy?	☐	☐
Have you had a first or second trimester screening test for Down Syndrome?	☐	☐
Have you had a chorionic villus sampling or an amniocentesis?	☐	☐
Have you had carrier testing for cystic fibrosis?	☐	☐

Emergency Contact Person:

Name: _____ Phone Number: _____

Form # OBC/MI-001 / 05.09

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DOS: _____

Have you ever had:

	No	Yes		No	Yes
Anemia	☐	☐	Kidney disease	☐	☐
High Blood Pressure	☐	☐	Urinary infections	☐	☐
Diabetes	☐	☐	Transfusions	☐	☐
Heart disease	☐	☐	Herpes Virus	☐	☐
Heart murmur	☐	☐	Infertility/IVF	☐	☐
Autoimmune disease	☐	☐	Surgery on cervix	☐	☐
Tuberculosis	☐	☐	Asthma or lung disease	☐	☐
Sickle Cell disease	☐	☐	Blood clot/DVT	☐	☐
Uterine anomaly	☐	☐	Gall bladder disease	☐	☐
Migraine headaches	☐	☐	Cancer	☐	☐
Hepatitis	☐	☐	HIV	☐	☐
Thyroid disease	☐	☐	Depression	☐	☐
Seizures/epilepsy	☐	☐	Rh(D) sensitized	☐	☐

Family History: Have you or any relative (including father and his family) ever had:

	No	Yes		No	Yes
Diabetes	☐	☐	Tay Sachs	☐	☐
Heart disease	☐	☐	Huntington Chorea	☐	☐
Heart attack	☐	☐	Ashkenazi background	☐	☐
Stroke	☐	☐	Canavan disease	☐	☐
High Blood Pressure	☐	☐	Familial Dysautonomia	☐	☐
Cystic Fibrosis	☐	☐	Sickle Cell disease	☐	☐
Recurrent Preg loss	☐	☐	Hemophilia	☐	☐
Thalassemia	☐	☐	Muscular dystrophy	☐	☐
Spina Bifida	☐	☐	Mental retardation	☐	☐
Congenital Heart Defect	☐	☐	Fragile X syndrome	☐	☐
Down Syndrome	☐	☐			

Alcohol use? ☐ No ☐ Yes Illegal drugs? ☐ No ☐ Yes
Tobacco? ☐ No ☐ Yes _____ Pks/day Years _____

Social History: Type of Work: _____

Any other problem? _____

_____

_____

 Completed by: _____

Reviewed with patient by: Physician's Signature: _____ Date: _____