



NEW OBSTETRIC PATIENT FORM

DATE: _____ PHONE NUMBER: _____

NAME: _____ AGE: _____ DOB: _____

HEALTH INSURANCE: _____ (please bring your card to your first visit)

Please fill out the information below to the best of your ability:

- First day of last menstrual period: _____
- How many pregnancies have you had (including this one): _____
- If you have had a pregnancy in your past, how many children have you delivered: _____
- Have you ever had a miscarriage, and if yes, please specify how many: _____
- Do you have any chronic health conditions:
 - Type 1 or 2 Diabetic
 - Hypertension
 - Cardiac Issues
 - Asthma or Respiratory Issues
 - Any other chronic issues: _____
- Have you received prenatal care for this pregnancy anywhere else, if yes, where:

If this is your first pregnancy, you may stop here. If this is not your first, please continue:

- Where did you deliver your last pregnancies: _____
 - If you did not deliver at DHCHD please obtain a medical record release so that we can obtain your records for your last deliveries.
- How many vaginal deliveries have you had: _____
- How many C-sections have you had: _____
- Did you have any complications during your last pregnancy?
 - Preeclampsia
 - Pre-term labor
 - Hypertension
 - Gestational Diabetes
 - Placed on Bedrest
- Did any of your newborns have complications or genetic abnormalities: _____
 - If yes, please list: _____

Please know that if you are scheduled for an appointment with one of our providers, this does not guarantee they will be able to keep you as a patient, you may be referred to one of our other providers or to a higher level of care obstetrics provider.