McFarland Clinic

Obstetrics & Gynecology
Prenatal Data Form

Date______________

Name:____________________________ Age:______Birthdate:_____________MRN____________

Occupation:________________________ Highest level of education completed:_______________

Country of Origin:__________________ Insurance Provider:_______________________________

Phone:____________________ Primary Care Physician: _________________________________

Marital status:___________ Partner name:_________________ Partner Occupation: ___________

Weight before pregnancy:_________ Height__________ Pets in the home? Yes __ No __

Current Pregnancy Information:

First Day of Last Menstrual Period?___________ Was it normal? Yes__ No__
If not, how was it different?______________________________
Were you using any form of contraception at time of conception? Yes__ No__
If so, what kind?_________________ When did you stop using it?_____________________
Average number of days between your periods?__________ How many days of blood flow?_________
Symptoms you have experienced since becoming pregnant? (check all that apply)

Tender breasts___
Nausea___
Vomiting___
Vaginal spotting/bleeding___
Menstrual cramping pain___
Other pelvic pain___

Back pain___
Fever/Chills___
Headaches___
Weakness/energy loss___
Dizzy/fainting spells___
Frequent urination___

Pain/burning with urination___
Diarrhea___
Constipation___
Black/bloody stools__

Medications/supplements used during this pregnancy:____

Pregnancy History:

Total # of pregnancies:_______ Births before 37 weeks:_____ Births at 37 weeks or more:_______
Miscarriages______ Elective abortions______ Ectopic/tubal pregnancies____ Living children:_____
Breech_____ Preeclampsia/High blood pressure____Gestational Diabetes_____
Insulin or diet controlled_____ Bedrest for any reason____ Babies with birth defects____
Postpartum depression____

Child's Name	Sex	Birthdate	Weeks Gestation	Labor Hours	Birth-weight	Type of delivery	Epidural	Complications	Location of birth

Past Medical History:

Allergies_____________________

Have you ever had a sensitivity to Latex?____If yes, have you had an allergy test for it?_____

Have you ever been hospitalized or had any surgery? Please list:

a____Date___________

b____Date___________

c____Date___________

d____Date___________

Have you ever had any problems with anesthesia?____If yes, what problem did you have?____

Have you ever had a blood transfusion?__________________________________

Do you have a history of infertility problems?_______________________________

Have you ever had any abnormality of female organs?_______________________

At what age did you have your first menstrual cycle?_________________________

At what age did you have your first sexual intercourse?______How many partners in your lifetime?_______

Have you or your partner ever had genital herpes?____

Do you have a history of a STD? Gonorrhea____Chlamydia____Syphillis___HPV___

Do you have a history of HIV, Hepatitis B or C?________

Are you sexually active currently?_____Do you have sex with Male___Female____Both____

Have you ever had Chicken pox?______Tuberculosis?________MRSA?__________

When was your last Tetanus or Tdap vaccine?__________Flu vaccine?___________

Covid vaccine?__________

Have you ever had any concerns with anxiety or depression?________________

Have you ever used medication for anxiety or depression?_________________

Social History:

Alcohol: No___ Yes___Drinks per day/week?________With pregnancy?________

Smoking: No___Yes___Packs per day?____Number of years?_____Quitdate?______

Vaping: No___Yes___Amount per day?_____Number of years?______

Drug use: No___ Yes____Frequency?______Marijuana___Meth__Cocaine__Herion__Opioids__

History of abuse?______ Physical?_____Emotional?____Sexual?_____

Do you feel safe currently?_____

Family History:

Have you or anyone in your family(parents, grandparents, siblings, children) had any of the following:

Rheumatic fever___	Thyroid problems__	Depression/Anxiety___
Kidney Disease___	High Blood pressure___	Varicose veins/blood clots___
Liver Disease___	Cancer___	Asthma___
Heart Disease____	Birth defects/inherited disease___	Seizures/Epilepsy___
Urinary tract infections___	Diabetes___	Other pertinent family history___