MADIGAN ARMY MEDICAL CENTER

Department of OB/GYN Obstetric History Form

Name: _____ Date:_____
Date of Birth:_____ Pronouns: _____
Phone number for a detailed message with personal health information:_____
MHS Genesis patient portal is the standard method for communication in the OB/GYN Department:
□ I can use the Portal □ I **CANNOT** access the Portal

Where is your preferred pharmacy? □ Madigan Pharmacy □ Other (name & location)_____
Do you have paperwork that needs to be filled out today? □YES □NO
Have you been to the ER or L&D for pregnancy problems since your last visit here? YES NO

What is the most important problem we can address for you today?

_____

What would make you completely satisfied with the healthcare you receive at this visit?

_____

Are you in pain today? YES NO If yes, where is your pain? _____

Are you having? (check for YES)
Constitutional: □Fever/Chills/Body aches □Swollen hands/face □Changes in vision □Headache
Respiratory: □Cough □Difficulty breathing
GI: □Nausea or vomiting □Abdominal pain
GU: □Contractions □Vaginal bleeding □Loss of fluid (water broke)
Fetal: □Not feeling your baby move (after 20 weeks)

Have you had a flu shot (Sept-May)? YES / NO / DON'T WANT FLU SHOT
Have you had your COVID vaccine? 1 SHOT / 2 SHOTS / 3 SHOTS / DON'T WANT COVAX
If you are in your third trimester, have you had your TdaP vaccine? YES / NO / DON'T WANT TDAP

Medications (please include all prescriptions, over the counter medications, prescription medications that weren't prescribed to you, herbs, vitamins or alternative therapies):
Are you taking your prenatal vitamins? □YES □NO

Do you have any medications that need to be refilled? □YES □NO

What information can we provide you to help you improve your health today?

□ Healthy eating/nutrition	□ Relationship help	□ Mental health/behavioral health
□ Vaccines I should get	□ Safer sex practices	□ Parenting/New Parent Support
□ Quitting tobacco	□ Childbirth Education	□ Breastfeeding Education
□ Exercise	□ Addiction (drugs, alcohol)	□ Birth control options for postpartum

To the best of my knowledge I have completed this form accurately. I understand that providing incomplete or inaccurate information can be dangerous to my health.

Signature:_____ Date:_____

OB Nursing Form

Vital Signs:
BP:_____ P:_____ RR:____ T:_____ Ht:_____ Wt:_____ FHT:_____

Current Gestational Age: _____ REPEAT BP: _____

EDD: _____ Room:_____

Allergies:

1._____ **Tob/ecig:** ☐ YES ☐ NO

2._____ **ETOH:** ☐ YES ☐ NO

3._____ **PAIN:** ☐ YES ☐ NO (__/10)

4._____ G___T___P___A___LC___

Current EGA:_____+_____

Tests:
☐ Blood type _____
☐ GC/CT _____
☐ Pap smear _____
☐ HPV NEG / POS
☐ GTT _____
☐ CBC _____
☐ GBS NEG / POS
☐ HCG _____

Influenza shot: ☐ Received ☐ Not Received
Rhogam: ☐ N/A ☐ Received ☐ Not Received
TdaP (if >28wk): ☐ Received ☐ Not Received
Preadmit (if >24wk): ☐ Received ☐ Not Received
Breastpump rx (>24wk): ☐ Received ☐ Not Received
COVID Vaccine: ☐ Received ☐ Not Received

EDPS:_____ #10:_____