Lexington Maternal Fetal Medicine
A Lexington Medical Center Physician Practice

Lexington Medical Park 2
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LexingtonMaternal.com

Patient History

Date:_____

Name:_____ DOB:_____ Race:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

OB Provider:_____

Pregnancy History

Year	Hospital	# of Weeks	Hrs/ Labor	Type of Delivery	Sex of Baby	Baby Weight	Complications
				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			
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				☐ Cesarean ☐ Vaginal ☐ Miscarriage ☐ Abortion			

OB Review of Systems

Pregnancy
☐ Vaginal bleeding
☐ Increased vaginal discharge
☐ Pelvic cramps
☐ Lower back pain
☐ Pressure in vagina

GI
☐ Nausea
☐ Vomiting
☐ Acid indigestion
☐ Constipation
☐ Frequent stools of diarrhea

Cardio Pulmonary
☐ Shortness of breath
☐ Fast heart beat
☐ Pain in chest
☐ Cough
☐ Excess sputum

GU
☐ Fever
☐ Frequent urination
☐ Pain when urinating
☐ Blood in urine

Neuro
☐ Dizziness
☐ Falling/lose of balance weakness
☐ Blurred vision

Skin
☐ Swelling in legs
☐ Frequent or easy bruising
☐ Skin rash

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Medical Condition	Age of Diagnosis
☐ Alcohol abuse	
☐ Allergies	
☐ Anxiety	
☐ Asthma	
☐ Bipolar disorder	
☐ Cancer:_____	
☐ Clotting disorder:_____	
☐ Depression	
☐ Diabetes	
☐ Drug abuse:_____	
☐ Fibromyalgia	
☐ Glaucoma	
☐ Heart disease	
☐ Hypertension	

Medical Condition	Age of Diagnosis
☐ Kidney disease	
☐ Infertility	
☐ Liver disease:_____	
☐ Lung disease:_____	
☐ Lupus	
☐ Premenstrual syndrome	
☐ Rheumatoid arthritis	
☐ Schizophrenia	
☐ Seizures	
☐ Thyroid ☐ over-active ☐ under-active	
☐ Urinary incontinence	
☐ Urinary tract infections	
☐ Other:_____	
☐ Other:_____	

Medications

Name of Medicine	Strength	How often?	Name of Medicine	Strength	How often?

Allergies

Have you had a reaction to any drug, chemical, or latex? ☐ Yes ☐ No

Please list the names of these drugs or chemicals:	➔	Please list the type of reaction to the drug:
1.	➔	
2.	➔	
3.	➔	
4.	➔	
5.	➔	

Past Surgeries

Procedure	Year	Procedure	Year
☐ Tonsillectomy		☐ Treatments for abnormal pap smears	
☐ Adenoidectomy		☐ C/S	
☐ Tubes in the ears		☐ D&C for miscarriages/bleeding	
☐ Appendix		☐ Ortho - cast/pins/plates/screws	
☐ Gallbladder			

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Personal History

What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your occupation? ☐ Student ☐ Homemaker

☐ Professional, please state job title:_____

How much do you smoke? ☐ N/A _____ packs per day

How many alcoholic beverages do you drink per day?

☐ N/A _____

Do you use recreational drugs? ☐ Yes ☐ No

Have you ever had a problem with addiction to drugs or alcohol?

☐ Yes ☐ No

If so, what was your drug(s) of choice?

_____

Family History

Relative	Illnesses (mental and medical) and age at diagnosis if known
Mother:	
Father:	
Brother:	
Brother:	
Sister:	
Sister:	
Daughter:	
Other:	
Other:	

Signature:_____ Date:_____

Print Patient Name:_____ DOB:_____