



Name _____ Doctor _____

Phone number _____ Work number _____

Height _____ Weight _____ Date of birth _____ Age _____

Allergies verified in EMR

Medications _____

Reason for ultrasound _____

Problems this pregnancy _____

Last menstrual period _____

Due date your doctor's given you _____

Prior ultrasounds this pregnancy when/where _____

Due date by ultrasound _____

Total pregnancies _____

Live births _____

Stillbirth _____

Miscarriage _____

Elective abortion _____

Tubal/ectopic pregnancy _____

Check appropriate box if you have the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Cesarean section | <input type="checkbox"/> High blood pressure in pregnancy | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Preeclampsia/toxemia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Death of a child | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Baby over 9 pounds | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Baby under 5 pounds | <input type="checkbox"/> Mitral value prolapse | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Diabetes – Type 1 | <input type="checkbox"/> Seizures | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Diabetes – Type 2 | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Family history of birth defects, mental retardation, Down syndrome |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood clots | |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Surgeries _____ | | |



Perinatal Center
PATIENT H&P INFORMATION

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