Boston University Chobanian & Avedisian School of Medicine
Physician Assistant Program

Student Name(s)____

Prenatal Care Workshop History Form (*This form is used as an educational experience for students and is not part of a medical record. It should be handed to the instructor at the end of the workshop.)*

Date: ___________________

Name: ____ DOB: ____________________ Age: ______

LMP: ____________ LNMP: _________________ Cycle Length: _________ Regular cycles? Yes No

Home pregnancy test? Yes No Date of positive test: _________

Obstetrical History

Total Pregnancies	Full Term	Premature	Ab spontaneous	Ab induced	Ectopic	Multiple births	Stillbirths	Living children

Previous Pregnancies

Date of Delivery	GA (weeks)	Length of Labor	Birth weight	Sex	Type of Delivery	Place	Anesthesia	Preterm Labor Yes/No	Comments/Complications

Past Medical History:

____

____

Substance	Amt/Day PrePregnant	Amt/Day since LMP	Years of use	Current use
Tobacco				
Alcohol				
Recreational drugs				

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Medications: ______________________________________ Allergies: __________________________________

Occupation: ____ Hobbies: ____

Past Surgical History:

____

____

Uterine surgery? Yes No Details: ____

Tubal surgery? Yes No Details: ____

Family History:

Maternal Relation	Age	Age at Death	Cause of Death	Medical condition	Medical condition	Medical condition	Medical condition
Father							
Mother							
Sibling							
Sibling							
Sibling							
Mat GM							
Mat GF							
Pat GM							
Pat GF							
Paternal Relation	Age	Age at Death	Cause of Death	Medical condition	Medical condition	Medical condition	Medical condition
Father							
Mother							
Sibling							
Sibling							
Sibling							
Mat GM							
Mat GF							
Pat GM							
Pat GF							

Notes:

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