8001 Youree Drive, Suite 600
Shreveport, LA 71115

WK PIERREMONT
OB-GYN Specialists

(318) 212 - 3890
pierremontobgyn.com

New OB Patient Information

Name:________________________ **Age:**_______ **DOB:**___________ **Today's Date:**_________

Last Menstrual Period: ______________

Pregnancy History

Have you ever been pregnant? Yes or No

If yes, please list each pregnancy in order – include any miscarriage, abortion, or ectopic pregnancies

	Month/Year	vaginal/c-section/miscarriage	gestation at delivery	weight of infant
Example:	1. 6/2017	miscarriage	7 weeks	
	2. 10/2019	vaginal	38 weeks	7lb

Pregnancy #1 ____

Pregnancy #2 ____

Pregnancy #3 ____

Pregnancy #4 ____

Pregnancy #5 ____

Gynecologic History

Date of last pap smear: ________________

History of abnormal Pap smears? Yes or No *If yes, what year?* ________________________

History of sexually transmitted infection? Yes or No

If yes, please circle all that apply: Gonorrhea Chlamydia Trichomonas HIV Syphilis Herpes Hepatitis B or C

Personal Medical History

Who is your primary care physician (PCP)? ____________________________________

Please review **medical problems or diagnoses:**

	Yes	**No**		**Yes**	**No**
Hypertension	______	______	Thyroid Disorder	______	______
Diabetes	______	______	Depression/Anxiety	______	______
Asthma	______	______	Autoimmune Disorder	______	______
Heart Disease	______	______	Tobacco Use	______	______
Kidney Disease	______	______	Alcohol Use	______	______
Seizure/Epilepsy	______	______	Drug Use	______	______
Hepatitis/Liver Disease	______	______			

Medical condition(s) not listed above: ____

Please list any **surgeries** you have had below

	Surgery	Year	Surgeon
Example:	gallbladder removed	June 2015	Dr. Jane Doe

1. ____
2. ____
3. ____
4. ____
5. ____

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Name:_______________________________ **Age:**_______ **DOB:**____________ **Today's Date:**__________

Personal Genetic History

Please indicate any family history of the following conditions in yourself or the father of the baby

	Yes	No		Yes	No
Neural Tube Defect	______	______	Hemophilia	______	______
Congenital Heart Defect	______	______	Tay-Sachs	______	______
Down Syndrome	______	______	Familial Dysautonomia	______	______
Cystic Fibrosis	______	______	Canavan Disease	______	______
Thalassemia	______	______	Muscular Dystrophy	______	______
Sickle Cell Disease	______	______	Mental Retardation/Autism	______	______
Blood clotting disorder	______	______	PKU	______	______

Please indicate any birth defects or familial disorders not listed above: ______________________________

____

Please list all **medications** that you are currently taking – include any prescriptions, over the counter medicines, supplements, or herbal remedies.

Please let the nurse know if you have a written list with you rather than writing list below

	Medication	Dose
Example:	Nifedipine	30 mg once daily

1. ____
2. ____
3. ____

Please list any **allergies** you have along with reaction.

Example: Latex – itching/rash

1. ____
2. ____
3. ____

Family Medical History

Has anyone in your family ever had any of the following:

Breast cancer - Yes or No If yes, who? Age at diagnosis? ______________________________

Ovarian cancer - Yes or No If yes, who? Age at diagnosis? ______________________________

Uterine/Endometrial cancer - Yes or No If yes, who? Age at diagnosis? ___________________________

Colon cancer - Yes or No If yes, who? Age at diagnosis? ______________________________

Please list any other significant family history: ____

____

The above information was completed by ________________________. I testify that the information on this form is complete and correct to the best of my knowledge.

______________________________	__________________________	__________________
Patient Signature	*Print Name*	*Today's Date*