Colorado Obstetrics & Women's Health

New Pregnancy Form

Name: _____ Date of Birth: _____

Father of Baby's Name: _____ Occupation? _____

First day of your last menstrual period? _____
Date of positive pregnancy test? _____
Was this pregnancy conceived on birth control?
☐ YES ☐ NO If so, what kind? _____

How old will you be by your due date? _____ years old.

Is this pregnancy the result of infertility treatments?
☐ YES ☐ NO If so, what kind? _____

Infection History. Have you ever had:

☐ Toxoplasmosis
☐ German Measles (Rubella)
☐ Herpes/ Cold Sores
☐ STDs/ HPV, If so, what? _____
☐ Rash/ Viral Illness since LMP?
☐ Vaginal/Rectal Group B Strep (GBS)
☐ Chicken Pox/ Shingles
☐ AIDS/ HIV
☐ Hepatitis, If so, which? _____

Do you own a cat? ☐ YES ☐ NO If yes, who changes the litter box? _____
Do you eat wild game or raw meat? ☐ YES ☐ NO If yes, explain: _____
Have you had known exposure to Tuberculosis? ☐ YES ☐ NO If yes, explain: _____
Do you have exposure to radiation? ☐ YES ☐ NO If yes, explain: _____

For **both you and the father** of the baby, is there a family history of:

Mother's Family	Father's Family	Mother's Family	Father's Family
☐	☐ Cerebral Palsy	☐	☐ Congenital (born with) Disorders
☐	☐ Consanguinity (incest)	☐	☐ Congenital (born with) Heart Disease
☐	☐ Down's Syndrome	☐	☐ Cleft Lip/Palate
☐	☐ Mental retardation	☐	☐ Cystic Fibrosis
☐	☐ Huntington's Disease	☐	☐ Hemophilia
☐	☐ Muscular Dystrophy	☐	☐ Neural tube defect
☐	☐ Sickle Cell Disease	☐	☐ Tay-Sachs
☐	☐ Fragile X positive	☐	☐ Thalassemia A or B
☐	☐ Twins	☐	☐ Other _____

I am of the following ethnicity: (please check)

☐ Asian ☐ Caucasian ☐ Native American ☐ Jewish
☐ African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ Other

The father of the baby is of the following ethnicity: (please check)

☐ Asian ☐ Caucasian ☐ Native American ☐ Jewish
☐ African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ Other

Patient's Signature: _____ Date: _____

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