

Pregnancy History: (please address all that apply to each pregnancy)

year	# weeks or months	mis-carriage or abortion	pre-mature (weight)	full-term (weight)	vaginal	forceps &/or vacuum	cesarian section (why?)	hours of labor

Surgical History:

name of procedure	reason for procedure	date of procedure

Allergies to Medications:

name of medication	rash	hives	nausea	other

Social History:

Place of Birth: _____ Profession/Employment: _____

Hobbies: _____

Habits:

___ Smoking ___ cigarettes/packs per day for ___ years
___ Alcohol Type: _____ How much? _____ How often? _____
___ Marijuana or other drugs: _____

Please list any other information you feel is relevant, including History of Medical problems in your Family members:
