Barnet Medical Plaza
680 Broadway, Suite 111 Paterson N.J. 07514
P: 973.977.6662 F: 973.341.1128
Towne Centre
3 Walter E. Foran Blvd., Suite 312 Flemington N.J. 08822
P: 908.284.2300 F: 908.442.7432

OBSTETRICAL HISTORY FORM

Patient Name: ______________________________ PID#: ____________

Age: ____________ Date of last menstrual period: ____________

Positive Pregnancy Test ☐Yes ☐No Home or Blood Test? ____________

Reason for the exam ordered: ______________________________

Symptoms: ______________________________

Do you have any concerns or worries with this pregnancy? ____________

Total # of Pregnancies: ____________ Total # of Miscarriage/Abortion: ____________
(Including this one)

Taking any medications? ☐ Yes ☐No Type: ____________

Check all that apply:

- ☐Nausea/Vomiting
- ☐Abdominal pain or Pelvic pressure
- ☐Back pain
- ☐Bleeding
- ☐Cramping
- ☐ Hypertension (HTN)
- ☐ Diabetes
- ☐Insulin dependent

History of:

- ☐Premature delivery
- ☐Ectopic Pregnancy
- ☐Abnormal Pap-Smear
- ☐Previous C-Section
- ☐LEEP procedure

Previous birth defect or abnormality? ☐Yes ☐No
Specify: ______________________________

Patient Signature: ______________________________