PRENATAL HISTORY

Format of History – same as a regular history including Review of Symptoms Add the following additional information regarding the OB/Gyn History

Student's name
Date of History
Patient's Name
Preceptor's Name

General Information (make sure these are included in the history)
- Patient's age
- Occupation
- Medications
- Allergies
- Hospitalizations
- Surgery
- Medical Conditions
- Family Genetic concerns
- Habits (Tobacco, Alcohol etc)

G(a)P(b)(c)(d)(e) Gravidity-number of pregnancies so a=number of pregnancies Parity-outcome of each pregnancy b=number of term pregnancies (>37 weeks) c=number of preterm pregnancies (viablility through 36 weeks) d=number of abortions (spontaneous or induced) and ectopic pregnancies e=number of living children
Specific information about each item should be included – such as mode of delivery and any complications involved in each past pregnancy

Present Pregnancy
- LMP (first day of last menstrual period)
  - Definite
  - Approximate (History of menses-?prior menses, ?monthly, ?#of days)
- Symptoms
  - N/V
  - Weight Gain
  - Edema
  - Vaginal Bleeding
- EDC (Expected Date of Confinement)
  - Naegele's Rule= LMP – 3 months + 7 days and 1 year
    - Example: LMP 9-10-2000 then EDC 6-17-2001
- History of medication use (including herbs or over the counter drugs)

Gynecologic History
- Last Pap Smear
- Gynecologic Disease and/or treatment
- History of Sexually Transmitted Disease (STD)
- History of Breast Disease or Cancer
- History of Infertility
- Sexual History
- Contraceptive History

Laboratory Data (helpful to add any additional information that you obtain from the history and initially prenatal visit)