BELLINGHAM

PATIENT NAME: _____ **Date:** _____

OB/GYN

☐ **No Current Medications** *(Please Include over the counter medications and vitamins/supplements)*

Medication:	Dose:

☐ **No Known Drug Allergies**

Drug Allergies (Medications):	Reaction:

☐ **No Surgical History**

Surgery:	Date:

Pregnancy History

☐ **No history of pregnancy**

Total	Full-term (37+ weeks)	Pre-term (Before 37 weeks)	Induced Abortion (Termination)	Spontaneous Abortion (Miscarriage)	Ectopic	Multiples	Living

Date	# of fetuses	Gestational Age	Labor length	Birth weight	Sex	Delivery type	Anesthesia	Delivery place	Name	Delivered by