SCOTTSBORO OB GYN SPECIALISTS LLC
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JERRY PIERCE MD IVONNE VARGAS MD PAUL MEGEHEE MD

NAME _____
DATE_____

1. How many children do you have?_____ date of birth/gender _____
_____
2. Have you ever had a miscarriage of abortion? _____If so, how many?_____
3. were any of your children born prematurely? _____
4. Were any of your children delivered by cesarean section?_____
5. Please list any previous operations (surgery) and date: _____
_____
6. Besides the time previously listed, have you ever been hospitalized? If so, please list dates and reasons
_____
7. Do you take any prescription drugs?
_____
8. Do you take any over the counter medicine regularly?
_____
9. Have you ever had any of the following diseases?
Diabetes _____Kidney Disease _____ Heart Disease_____ Epilepsy _____
Rheumatic Fever _____ Asthma _____ Hepatitis/liver disease _____
Mitral Valve Prolapse _____Phlebitis/varicose veins _____Thyroid Disease _____
Tuberculosis _____ Infertility _____
10. Do you smoke?_____ If so, how much per day? _____
11. Do you drink alcohol? _____ If so, how much? _____
12. Do you use street drugs? _____ If so, what and how much? _____
13. Have you ever been exposed to any of the following diseases?
Tuberculosis _____ Aids _____ Herpes _____ Hepatitis _____
Gonorrhea _____ Chlamydia _____
14. Has anyone in your family had any of the following? Neural Tube Defect _____
Down's syndrome _____ Tay Sach's Disease _____ Sickle Cell _____
Hemophilia _____ Muscular dystrophy _____ Cystic Fibrosis _____
Huntington chorea _____ Mental retardation _____ Genetic disorder _____
15. During this pregnancy, have you had any of the following problems: Headache _____
Vaginal bleeding _____ Abdominal bleeding _____ Fever _____

Vaginal Discharge/order _____ Urinary complaints _____Vomiting _____
Constipation _____ Other _____

16. When was your last menstrual period ? _____
17. when is your due date? _____
18. Are you allergic to any medicines ? _____
19. Race of baby's father _____