

# Obstetrics Flow Sheet (page 1 of 2)

Please print this form, fill it out, and either fax it or bring it with you for your visit. Thank you!



## Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Street Address \_\_\_\_\_ Age \_\_\_\_\_  
 City \_\_\_\_\_ ZIP \_\_\_\_\_ Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_  
 ( ) \_\_\_\_\_  Home  Cell  Work  
 ( ) \_\_\_\_\_  Home  Cell  Work Social Security No. \_\_\_\_\_  
 Hospital for Delivery \_\_\_\_\_ Pediatrician \_\_\_\_\_  
 Obstetrician \_\_\_\_\_ Breast \_\_\_\_\_ Bottle \_\_\_\_\_ Patient \_\_\_\_\_ Father \_\_\_\_\_  
 Baby's Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

**Tempe Office**  
 6301 S. McClintock Dr.,  
 Suite 215  
 Tempe, AZ 85283  
 Phone: (480) 820-6657  
 Fax: (480) 730-0803

**Gilbert Office**  
 2550 E. Guadalupe Rd.,  
 Suite 109  
 Gilbert, AZ 85234  
 Phone: (480) 505-4475  
 Fax: (480) 505-4252

Racial Background: \_\_\_\_\_

### For Doctor's Use Only

**PREGNANCY HISTORY:** Grav Para SAB T/EAB Stillborn Neonatal Death Other Loss Premature

No.	Date	Weeks	Sex	Wt.	Delivery Mode	Obstetrical Problems	Neonatal Problems

**PATIENT HISTORY**  
 PMH \_\_\_\_\_  
 PSH \_\_\_\_\_  
 GYNHX \_\_\_\_\_  
 Meds \_\_\_\_\_  
 Allergy \_\_\_\_\_  
 SocHx (ETOH, TOB, drugs) \_\_\_\_\_  
 Fertility HX \_\_\_\_\_  
 Chemical/XRT, Exposure \_\_\_\_\_  
 Blood Transfusion \_\_\_\_\_  
 Cat/Toxo \_\_\_\_\_ CMV \_\_\_\_\_ Listeria \_\_\_\_\_  
 Parvo \_\_\_\_\_ Varicella \_\_\_\_\_  
**FAMILY HX**  
 Breast CA/GYNCA \_\_\_\_\_  
 HTN \_\_\_\_\_ DM \_\_\_\_\_  
 Bleeding D/O (Hemophilia) \_\_\_\_\_  
 Birth Defects/CP/Downs \_\_\_\_\_  
 Inherited D/U (CF/Muscular D/O) \_\_\_\_\_  
 African American/Sickle Cell \_\_\_\_\_  
 Jewish/Tay Sachs \_\_\_\_\_  
 Prior genetic testing/counseling \_\_\_\_\_  
 Mother ≥ 35 y.o. \_\_\_\_\_  
 Father ≥ 50 y.o. \_\_\_\_\_

**INITIAL PHYS. EXAM**  
 Weight \_\_\_\_\_ Pre-OB Wt. \_\_\_\_\_ Height \_\_\_\_\_  
 BP \_\_\_\_\_ Pulse \_\_\_\_\_ HEENT \_\_\_\_\_  
 Thyroid \_\_\_\_\_  
 Breasts \_\_\_\_\_  
 Heart \_\_\_\_\_  
 Lungs \_\_\_\_\_  
 Abdomen \_\_\_\_\_  
 Back \_\_\_\_\_  
 Extremities \_\_\_\_\_  
 Vulva \_\_\_\_\_  
 Vagina \_\_\_\_\_  
 Cervix \_\_\_\_\_  
 Uterus \_\_\_\_\_ est. wks \_\_\_\_\_  
 Adnexae \_\_\_\_\_  
 Pelvis \_\_\_\_\_  
 Provider Name: \_\_\_\_\_

