Obstetrical History Questionnaire

Name: _____ Date: _____
(Last) (First)

Please list all of your pregnancies in chronological order. Include all liveborn, stillborn, miscarriages, ectopic, abortions etc.

PREGNANCY	MONTH/ YEAR	# OF MONTHS PREGNANT	LIVEBIRTH/ STILLBORN/ OR LOSS	VAGINAL DELIVERY OR CESAREAN	SEX OF BABY	WEIGHT OF BABY	PROBLEMS WITH PREGANCY OR DELIVERY
1ST							
2ND							
3RD							
4TH							
5TH							
6TH							
7TH							
8TH							
9TH							
10TH							
11TH							