

Youth For Tomorrow

11835 Hazel Circle Dr.
Bristow, VA 20136

OB/GYN ASSESSMENT

Patient Name: _____ D.O.B.: _____

History:

Has patient been pregnant before? _____ When? _____

Has patient previously given birth? _____ When? _____

Reported history of family diabetes and or gestational diabetes? **YES** _____ **NO** _____ **Detail below:**

Reported history of OB/GYN problems? _____ **YES** _____ **NO** _____ **Detail below:**

Is this patient pregnant? **YES** _____ **NO** _____ Approximate due date? _____

HCG Results: _____

Does this pregnancy present an unusually high risk? **YES** _____ **NO** _____

➤ If presenting an unusually high risk, what is the nature of such risk? _____

Medications or prescribed: _____

Recommendations for care or other follow-up: _____

Next appointment date: _____ Appointment time: _____

Physician Signature: _____ **Date:** _____

Physician Tel. No: _____ **Physician Fax No:** _____