Gestational Carrier OB/GYN Physical Form

Patient Information

Patient Name ______________________________ DOB ______ /______ /________

Current Medications ______________________________ Allergies ______________________

Height ____________ Weight ____________ Blood Pressure ____________

Exam History

Date of Last Exam (if done within the last 12 months) ______ /______ /________

Physical Exam Findings (Please attach report) ______________________________

Significant Medical History ______________________________

Surgical History ______________________________

Date of Last Pap Smear ______ /______ /________ Next Pap Due ______ /______ /________

Pap Smear Result (Please attach report) ______________________________

Does the Patient Have a History of Abnormal Pap? ☐ Yes ☐ No

If Yes, Please Describe Treatment Course and Currrent Status ______________________________

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Pregnancy History

Year	Check here if SAB	Check here if TAB	Check here if Ectopic	Check here if Delivered	Weeks of Gestation	Type of Delivery	# of Babies Delivered

Explain Any Pregnancy Complications in Detail ______________________________

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Pregnancy History Continued

Question	Yes	No
Has the patient ever had any trouble conceiving?	☐ Yes	☐ No
Has the patient ever been diagnosed with gestational diabetes?	☐ Yes	☐ No
Has the patient ever had high blood pressure dureing pregnancy?	☐ Yes	☐ No
Has the patient ever had an eating disorder?	☐ Yes	☐ No
Has the patient ever had post-partum depression?	☐ Yes	☐ No
Has the patient ever experienced issues pertaining to overactive or underactive thyroid?	☐ Yes	☐ No

Please Perform

Breast Exam Findings ____

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Please Provide Any Additional Notes

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☐ **Based on this patient's recent physical, medical and obstetrical history, they are medically recommended for pregnancy.** **Note: please sign this form only if you are a practicing obstetrician, a certified nurse midwife, or a primary care physician who delivers babies*

Physician or CNM Signature ______________________________ Date ______ /______ /________

Printed Name ______________________________ City/State______________________________