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 _____

_____

Pregnancy History

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

Explain Any Pregnancy Complications in Detail _____

_____

_____

_____

Pregnancy History Continued

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 during 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 _____

_____

Please Provide Any Additional Notes

_____

_____

_____

_____

☐ **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_____

Please email this form to gcreview@ormfertility.com

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