OB History – International Patients

Please allow up to 3 business days for a response from our office. To expedite our review, please make sure to answer all questions and provide details on any particular problems you have had in previous or your current pregnancy.

GENERAL INFORMATION

Name that appears on your passport: (You will be registered under the name shown on your passport)

Last Name: ____________________ First Name: ______________________ Middle/Surname: __________________

Preferred First Name: ______________________

Married Last Name: ______________________

Your Date of Birth: MONTH: ___________________ DAY: _________________ YEAR: ___________________

Country You Reside and Are Receiving Prenatal Care: ____
Have you begun receiving prenatal care? ___________________ If not, please respond once prenatal care has begun.

At the time of your baby's birth, how old will you be? _____________________

Do You Have a Current Passport? ________________ Passport #: ____

Email Address to contact you: ____
In order to ensure timely correspondence, please list ONE email address ONLY – provide the email you use most often.

Husband's Name: Last Name: __________________________________ First Name: _________________________

Date you plan to arrive in Houston: ____

Do you have insurance that can assist you with your obstetrical costs? (physician, hospital, anesthesia, pediatrician, etc.)

Who referred you to Dr. La? ____

PREGNANCY HISTORY

Starting with your very first pregnancy (**including all Elective Terminations of Pregnancy (ETOP) and Spontaneous Abortions (SA) ("miscarriages", Fetal Demise (FD) or Full Term (FT)**, please provide the following information:

Pregnancy #:	Month & Year of Pregnancy:	ETOP, SA*, FD*, FT	Vaginal (V) or Cesarean (C)	Sex of Baby	# of Weeks @ Time of Delivery
1					
2					
3					
4					
5					
6					
7					

8					
9					

Have you had any complications with your current or past pregnancies (example: high blood pressure, HIV, preterm labor, diabetes/gestational diabetes).

If you have diabetes, are you currently on insulin or oral medications? _______________

PLEASE USE THE SPACE BELOW TO PROVIDE ADDITIONAL INFORMATION ABOUT ANY COMPLICATIONS OR FETAL DEMISE. (Please include the number of your pregnancy to identify the pregnancy you had problems):

____
____
____
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____
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____

First Date of Menstrual Period: ____
Estimated Delivery Date: ____

Are you pregnant with twins? _________________ What is their chorionicity and amnionicity (your physician may need to provide this information for you.)

What is your Genotype (AA, AS, SC, SS): ____
(Required for all non-Caucasian and non-Hispanic patients).

Can you accept blood if it became medically necessary? ___________________________________

Please return completed form to info@doctorla.com – Allow 2 **business days** for a response