

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth : \_\_\_\_\_

What name do you like to be called? \_\_\_\_\_

Do you have any allergies to medications: Y N

Medication: \_\_\_\_\_ Allergic reaction \_\_\_\_\_

Medication: \_\_\_\_\_ Allergic reaction; \_\_\_\_\_

### **Personal Medical History**

(This section pertains to the patient only. Please circle yes only if the condition has been diagnosed by a healthcare provider)

How old were you when you started having periods ? \_\_\_\_\_

First day of your last menstrual period?: \_\_\_\_\_ Is this a guess or are you certain?

Are your periods regular ? Yes No How long are your cycles? \_\_\_\_\_

Yes No Have you had or do you have any problems that affect your head, ears, eyes, nose or throat?  
If yes what is the problem? \_\_\_\_\_

Yes No Have you had or do you have any problems with your heart or cardiovascular system?  
If yes, what is the problem? \_\_\_\_\_

Yes No Have you had or do you have any problems with your lungs or respiratory system?  
If yes, what is the problem? \_\_\_\_\_

Yes No Have you had or do you have any problems with your stomach, intestines or gastrointestinal system?  
If yes, what is the problem? \_\_\_\_\_

Yes No Have you had or do you have any problems with your bladder, kidneys or urinary system?  
If yes, what is the problem? \_\_\_\_\_

Yes No Have you had or do you have any problems with depression, anxiety, mental health issues or your central nervous system?  
If yes, what is the problem? \_\_\_\_\_

Yes No Have you had or do you have a history of recurring infections?  
If yes, what type? \_\_\_\_\_

Yes No Have you had chicken pox?  
If yes, at what age? \_\_\_\_\_

Yes No Have you ever been diagnosed with herpes?  
If yes, when ? \_\_\_\_\_ Oral or Genital

Yes No Have you ever been diagnosed with any other sexually transmitted diseases? Y N  
If yes, when and what was diagnosed? \_\_\_\_\_

Yes No Have you ever had a blood transfusion?  
If so, when and why? \_\_\_\_\_

Yes No Do you know if you have been exposed to DES\*?  
• *Diethylstilbestrol (DES) is a nonsteroidal estrogen. DES was initially used for treatment of postmenopausal symptoms, and for prevention of miscarriage, premature birth, and other pregnancy problems. It was last used in 1971*

Yes No Have you had or do you have any problems with diabetes, thyroid or hormonal or endocrine system related concerns?  
If yes, what and when were you diagnosed? \_\_\_\_\_  
What treatment did you receive? \_\_\_\_\_

Yes No Have you ever been told you were anemic when you weren't pregnant?  
If yes, when? \_\_\_\_\_

Yes No Have you had or do you have a history of blood clots, varicose veins?  
If yes, when? \_\_\_\_\_

**Gynecological history:**

Yes No Have you ever had an abnormal pap smear? If yes, when? \_\_\_\_\_ How was it treated?  
Cryotherapy? Y N Colposcopy? Y N LEEP? Y N Cervical conization? Y N

Yes No Have you ever been physically or sexually abused? If yes, which and when? \_\_\_\_\_

**Surgical History**

Yes No Have you ever had any operations?  
If so, when and what type of surgery? \_\_\_\_\_  
When: \_\_\_\_\_ Type: \_\_\_\_\_  
When: \_\_\_\_\_ Type: \_\_\_\_\_  
When: \_\_\_\_\_ Type: \_\_\_\_\_  
When: \_\_\_\_\_ Type: \_\_\_\_\_

**Family History**

(This pertains to Grandparents, Parents and Siblings of the patient)

Yes No Diabetes? If yes, which relative: \_\_\_\_\_

Yes No Hypertension (High Blood Pressure) If yes, which relation: \_\_\_\_\_

Yes No Renal disease (Kidney related problems) If yes, which relation? \_\_\_\_\_

Yes No Cancer? If yes what type and which relation? \_\_\_\_\_

Yes No Twins? If yes which relation had the twins or is the twin? \_\_\_\_\_

Yes No Heart Disease? If yes, which relation? \_\_\_\_\_

Yes No Lung Disease? If yes, which relation? \_\_\_\_\_

Yes No Seizure Disorders If yes, which relation? \_\_\_\_\_

Are there any other medical conditions in your relatives that we should know about? \_\_\_\_\_

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**Genetic History**

(This pertains to the family history of both patient and father of the baby)

Yes No Will you be over 34 years old at time of the delivery of the pregnancy  
What will be the father's age at time of delivery? \_\_\_\_\_

Yes No Is there a family history of Sickle Cell Disease or Trait\*?  
*Sickle cell disease is a genetic disorder that affects the body's blood cells. Usually occurs in people of African descent.*

Yes No Is there a family history of Thalassemia\*? .  
*\* Thalassemia is a genetic disorder that causes the body to produce less hemoglobin, which helps the red blood cells to spread oxygen through your body. Usually occurs in people of Italian, Greek, Mediterranean or Asian descent.*

Yes No Is there a family history of Tay Sachs Disease\*?  

- *Tay Sachs Disease is a genetic disorder in which little or no hexosaminidase A enzyme is produced by the body. This enzyme is necessary to break down normal fatty compounds in the body cells. Usually occurs in people of Jewish, Cajun and French Canadian*

Yes No Is there a family history of Down Syndrome \*?  

- *Down Syndrome is a set of physical and mental traits caused by a gene problem that happens before birth*

Yes No Is there a family history of any other Mental Retardation?  
If yes, was the person tested for Fragile X? Yes No

- Yes No Is there a family history of Neural Tube Defects (Meningomyelocele, Spina Bifida or Anencephaly\*)?  
 • *Meningomyelocele is a hernia of the spinal cord and membranes through a defect in the vertebral Column*  
 • *Spina Bifida is a birth defect of the spinal column*  
 • *Anencephaly pertains to the development of the brain*
- Yes No Is there a family history of Cystic Fibrosis\*?  
 \**Severe disease with frequent episodes of pneumonia, thick respiratory excretions & poor digestion*
- Yes No Is there a family history of Huntington's Chorea\*?  
*An inherited disease of the central nervous system*
- Yes No Is there a family history of Muscular Dystrophy\*?  
 • *Muscular dystrophy is an inherited disorder that causes progressive muscle weakness and loss of muscle mass due to defects in one or more genes required for normal muscle function*
- Yes No Is there a family history of Hemophilia\*?  
 • *The hemophilias are a group of related bleeding disorders that most commonly are inherited.*
- Yes No Are there any other heritable conditions in your families?  
 If yes, which? \_\_\_\_\_
- Yes No Does the father of the baby have any other children with other birth defects?  
 If yes, what would they be? \_\_\_\_\_

### **OB History**

Is this your first pregnancy? Yes No (circle one) Was this pregnancy planned: Yes No (circle one)

How many pregnancies have you ever had *including this one*? \_\_\_\_\_

Have you had a miscarriage? Yes No If yes, how many? \_\_\_\_\_ When? \_\_\_\_\_  
 How many weeks pregnant were you at the time? \_\_\_\_\_ Did you need a D& C? \_\_\_\_\_

Have you had an abortion? Yes No (circle one) If yes, how many? \_\_\_\_\_ When? \_\_\_\_\_  
 How many weeks pregnant were you at the time? \_\_\_\_\_

Complete the following for each pregnancy (if you need more space please use another sheet of paper)

1. Delivery Date: \_\_\_\_\_ How many weeks were you at delivery? \_\_\_\_\_  
 How many hours were you in labor? \_\_\_\_\_ Vaginal Birth – (Forceps or Vacuum assisted) or C-section.  
 Why? \_\_\_\_\_  
 (circle one) Did you have an epidural? Y or N Gender M or F How much did the baby weigh? \_\_\_\_\_  
 Place of Delivery \_\_\_\_\_ Were there any complications with the pregnancy or delivery? \_\_\_\_\_

2. Delivery Date: \_\_\_\_\_ How many weeks were you at delivery? \_\_\_\_\_  
 How many hours were you in labor? \_\_\_\_\_ Vaginal Birth – (Forceps or Vacuum assisted) or C-section.  
 Why? \_\_\_\_\_  
 (circle one) Did you have an epidural? Y or N Gender M or F How much did the baby weigh? \_\_\_\_\_  
 Place of Delivery \_\_\_\_\_ Were there any complications with the pregnancy or delivery? \_\_\_\_\_

3. Delivery Date: \_\_\_\_\_ How many weeks were you at delivery? \_\_\_\_\_  
 How many hours were you in labor? \_\_\_\_\_ Vaginal Birth – (Forceps or Vacuum assisted) or C-section.  
 Why? \_\_\_\_\_  
 (circle one) Did you have an epidural? Y or N Gender M or F How much did the baby weigh? \_\_\_\_\_  
 Place of Delivery \_\_\_\_\_ Were there any complications with the pregnancy or delivery? \_\_\_\_\_

4. Delivery Date: \_\_\_\_\_ How many weeks were you at delivery? \_\_\_\_\_  
 How many hours were you in labor? \_\_\_\_\_ Vaginal Birth – (Forceps or Vacuum assisted) or C-section.  
 Why? \_\_\_\_\_  
 (circle one) Did you have an epidural? Y or N Gender M or F How much did the baby weigh? \_\_\_\_\_  
 Place of Delivery \_\_\_\_\_ Were there any complications with the pregnancy or delivery? \_\_\_\_\_

**Habits and Exposures**

(this portion pertains to the patient)

Yes No Do you smoke?  
Yes No Are you interested in cessation information  
Yes No Have you ever smoked? If yes, when did you quit? \_\_\_\_\_  
Yes No Did you quit for the pregnancy  
Yes No Do you drink alcoholic beverages? If yes, how many a week? \_\_\_\_\_  
Yes No Did you quit for the pregnancy  
Yes No Do you do recreational drugs? If yes, what and when? \_\_\_\_\_  
Yes No Did you quit for the pregnancy  
Yes No Are you currently on any medications? If yes, what and how much? \_\_\_\_\_

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Yes No Have you had any x-rays with this pregnancy? If yes, when and why? \_\_\_\_\_  
Yes No Are there any other exposures that we should know about? If yes, what and where are you exposed to them?

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**Other vital information**

**What type of work do you do?** \_\_\_\_\_

Yes No Is father of the baby involved in pregnancy - His name: \_\_\_\_\_ contact number: \_\_\_\_\_  
What is his occupation? \_\_\_\_\_ What is his ethnicity? \_\_\_\_\_

Yes No Does he have a history of genital herpes?

Yes No If you have a male baby do you want him circumcised?

Yes No Do you have a pediatrician? If yes, Name: \_\_\_\_\_

Yes No Are you planning to breastfeed?

Do you have a religious preference? \_\_\_\_\_. What is your ethnicity? \_\_\_\_\_

**General Information for the patient**

As part of your care it is necessary to obtain laboratory test. Below is a list of the tests we obtain at your initial visit. You should discuss these tests with your provider if you have any questions. You may decline to do any of the following tests however we ask that you discuss this decision with your provider. Please let your provider or the medical assistant know of any test you are declining. If you wish to decline any test or have any questions about any test please notify your provider

Blood Type and Rh – (ABO-Rh)                      Antibody Screen                      Complete Blood Count                      Hepatitis B surface antigen

HIV                      Rubella                      RPR                      Urinalysis                      Urine Drug Screen

and any others your provider deems necessary.

I have read the above and understand these tests are obtained to provide my healthcare provider with an overall view of my health status pertaining to pregnancy. I will discuss any concerns with my provider. I will inform my provider if I choose to decline any or all of the testing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by provider: \_\_\_\_\_ Date: \_\_\_\_\_