

OBSTETRIC MEDICAL HISTORY

Patient Name: _____ Social Security # _____

*If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

- Yes No Are you allergic to any medications? If yes, please list: _____

- Please mark any condition that you have or have had in the past:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Asthma
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Bowel disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Headaches	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Kidney disease/Stones	<input type="checkbox"/> Arthritis or lupus	<input type="checkbox"/> Depression	<input type="checkbox"/> Positive TB Skin Test
<input type="checkbox"/> von Willebrand's disease or other bleeding disorders	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Recurrent urinary tract infections	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood clotting disorder (eg, phlebitis)			

Describe, if needed: _____

- Please indicate any surgery that you have had: _____

- Please describe any health problems or symptoms that you are having at this time: _____

- Yes No Do you or any family member have a history of problems with anesthesia?
If yes, please describe: _____
- Yes No Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)?
If yes, please describe: _____

FAMILY HISTORY & GENETIC SCREENING

- Yes No Have you or has the baby's father had a child born with a birth defect?
If yes, please describe: _____
- Yes No Did either you or the baby's father have a birth defect?
If yes, please describe: _____
- Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis): _____

How is this child/person related to you? _____
- Yes No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)?
If yes, have either of you had genetic counseling? Yes No
If yes, have either of you had chromosomal testing? Yes No
Where and what were the results? _____
- Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

<input type="checkbox"/> Yes <input type="checkbox"/> No Eastern Europe Jewish ancestry	If yes, have you had Tay-Sachs screening tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, have you had a Canavan screening test? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date _____ Result _____
<input type="checkbox"/> Yes <input type="checkbox"/> No African American	If yes, have you had sickle cell screening <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No European Ancestry	If yes, have you had cystic fibrosis screening? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No Mediterranean Ancestry or Southeast Asian Ancestry	If yes, have you had screening for inherited forms of anemia such as thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No

6. Please list any other concerns you have about birth defects or inherited disorders:

7. Yes No Will you be 35 years or older at the time the baby is born? _____

8. Yes No Will the father be 50 years or older? _____

EXPOSURES AFFECTING HEALTH

1. Yes No Do you smoke cigarettes? If yes, how many packs per day? _____

2. Yes No Do you drink alcoholic beverages? If yes, how often? _____
What type of drinks? _____

3. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____

4. Please list any illicit or recreational drugs used since your last period (eg, cocaine, marijuana): _____

5. Yes No Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous drug use, multiple sex partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)?

6. Yes No Are you ever exposed to chemicals or radiation (eg, X-rays)? If yes, please describe: _____

7. Yes No Are you on a restricted diet? If yes, please describe: _____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____

Yes No Have you ever had an abnormal Pap test?
If yes, when and how were you treated? _____
What was the diagnosis? _____

2. Yes No Have you ever had gonorrhea , chlamydia , or pelvic inflammatory disease ?
If yes, when, how, and where were you treated? _____

3. Yes No Have you ever had herpes? If yes, how often do you have outbreaks? _____
 Yes No Have you ever had syphilis? If yes, how, when, and where were you treated? _____

4. Yes No Have you ever used an IUD (intrauterine device) for contraception?
If yes, please indicate when: _____

Yes No Did you have any problem with the IUD?
If yes, please describe: _____

5. Yes No Have you been treated for infertility?
If yes, please describe when and treatment received: _____

6. Yes No Do you have any other concerns related to your past health history?
If yes, please list: _____

Patient Signature _____

Print Name _____

Date _____

PSYCHOSOCIAL SCREENING

1. YES NO Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointment?
2. YES NO Do you feel unsafe where you live?
3. YES NO In the past 2 months, have you used any form of tobacco?
4. YES NO In the past 2 months, have you used drugs or alcohol (including beer, wine or mixed drinks)?
5. YES NO In the past year, have you been threatened, hit, slapped or kicked by anyone you know?
6. YES NO Has anyone forced you to perform any sexual act that you did not want to do?
7. YES NO On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
8. YES NO How many times have you moved in the past 12 months? _____
9. If you could change the timing of this pregnancy, would you want to
 Earlier Later Not at all No change

Patient Signature

Print Name

Date