OBSTETRIC MEDICAL HISTORY

Patient Name_____

Date_____

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

PERSONAL HEALTH HISTORY

1. Are you allergic to any medication? Yes ____ No ____

If yes, please list:_____

2. Please mark any conditions that you have or have had in the past:

Cancer____	HIV/AIDS____	Diabetes____
Epilepsy____	Thyroid disorder____	Eating disorder____
Heart Disease____	Headaches____	Depression____
High Blood Pressure____	Arthritis or lupus____	Asthma____
Kidney disease____	Frequent infections____	Anemia____
Hepatitis____	Bowel disease____	Herpes____

Blood clotting disorder (eg, phlebitis)____
Von Willebrand's disease or other bleeding disorders____
Sexually transmitted diseases____
Recurrent urinary tract infections____

Describe if needed:

_____
_____
_____

3. Please indicate any surgery or hospitalization that you have had:

_____
_____
_____

4. Please describe any health problems or symptoms that you are having at this time:

_____
_____
_____

5. Do you or any family member have a history of problems with anesthesia? Yes____ No____ If yes, please describe:

_____
_____
_____

6. Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)? Yes____ No____ If yes, please describe:

_____
_____
_____

EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? Yes____ No____.
If yes, how many packs per day?_____
If former smoker, when did you quit?_____

2. Do you drink alcoholic beverages now or did you before you became pregnant? (1.5 oz spirits = 12 oz beer) Yes____ No____
If yes, how often?_____
What type of drinks?_____

3. Please list any medication taken since your last period, including prescriptions, over the counter drugs, multivitamins, other suplements, and any herbal medicines:

_____
_____

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

_____
_____

5. Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)? Yes____ No____.

6. Are you ever exposed to chemicals or radiation (eg, X-rays)? Yes____ No____.
If yes, please describe:

_____

7. Are you on a restricted diet? Yes____ No____
If yes, please describe:

_____

GYNECOLOGIC HISTORY

1. When was your last Pap test?_____.
Have you ever had an abnormal Pap test? Yes____ No____.
If yes, when and how were you treated?

_____
What was the diagnosis?

_____

2. Have you ever had:

Gonorrhea____
Chlamydia____.
Pelvic inflammatory disease____
If yes, when, how and where were you treated?

_____

3. Have you ever had herpes? Yes____ No____
If yes, how often do you have outbreaks? _____.
Have you ever had syphilis? Yes____ No____
If yes, how, when and where were you treated?

_____
_____

4. Have you ever used an IUD (intrauterine device) for contraception? Yes____ No____.
If yes, please indicate when:_____.
Did you have any problems with the IUD? Yes____ No____.

If yes, please describe:

_____

5. Have you been treated for infertility? Yes____ No____
If yes, please describe when and treatment received:

_____

6. Do you have any other concerns related to your past health history?

_____

_____

FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity?_____
What is the ethnicity of the baby's father?_____

2. Have you or has the baby's father had a child born with a birth defect? Yes____ No____
If yes, please describe:

_____

3. Did either you or the baby's father have a birth defect? Yes____ No____
If yes, please describe:

_____

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, early infant death, deformities, or inherited diseases such as hemophilia, muscular dystrophy or cystic fibrosis):

_____

_____

_____

How is this child/person related to you?_____

5. Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)? Yes____ No____
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?

_____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, one of these backgrounds:

Eastern European Jewish (Ashkenazi) ancestry? Yes____ No____
If yes, have you had Tay-Sachs screening tests? Yes____ No____
If yes, have you had a Canavan screening test? Yes____ No____
If yes, have you had familial dysautonomia screening? Yes____ No____
Date:_____ Result:_____

African American? Yes____ No____
If yes, have you had sickle cell screening? Yes____ No____
Date:_____ Result:_____

European Ancestry & Eastern European Jewish (Ashkenazi) ancestry? Yes____ No____
If yes, have you had cyctic fibrosis screening? Yes____ No____
Date:_____ Result:_____

Mediterranean ancestry or Southeast Asian ancestry? Yes____ No____
If yes, have you had screening for inherited forms of anemia such as thalassemia?
Yes____ No____

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

8. Do you want to have a down syndrome risk assessment? Yes____ No____

9. Is the father 50 years or older? Yes____ No____

PSYCHOLOGICAL SCREENING

1. Do you have any problems (job, transportation etc.) that prevent you from keeping your health care appointments? Yes____ No____

2. Do you feel unsafe where you live? Yes____ No____

3. Are you exposed to second-hand smoke? Yes____ No____

4. In the past two months, have you used drugs or alcohol (including beer, wine & mixed drinks)? Yes____ No____

5. In the past year, have you been threatened, hit, slapped, or kicked by anyone you know? Yes____ No____

6. Has anyone forced you to perform any sexual act that you did not want to do? Yes____ No____

7. On a 1-5 scale (1 being low, 5 being high) how do you rate your stress level? ____

8. How many times have you moved in the past 12 months? _____

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_____
Patient Signature

_____
Print Name

_____
Date