PREGNANCY
OB/GYN HISTORY

In order to give you more complete medical care, we recommend an annual physical examination and certain appropriate laboratory studies.

Please answer as directly and briefly as possible the following medical history:

1) NAME:______________________________AGE:__________DATE: ______________

MARITAL STATUS: S M D W Separated__________ DATE OF BIRTH: ______________

OCCUPATION: ______________________BLOOD TYPE/RH SENSITIZATION: ______________

PRESENT PROBLEMS: ______________________________ HOW LONG? ________

1. ______________________________

2. ______________________________

PERSONAL HISTORY

Weight __________ Now ______________ 1 year ago ____________ Highest ____________________ When ________

2) HAVE YOU EVER HAD:	No	Yes
German measles	❑	❑
Mumps	❑	❑
Chicken pox	❑	❑
Scarlet fever	❑	❑
Diphtheria	❑	❑
Pneumonia	❑	❑
Rheumatic fever	❑	❑
Heart disease	❑	❑
Heart murmur	❑	❑
Polio or meningitis	❑	❑
Kidney infections	❑	❑
Chlamydia, Gonorrhea or syphilis	❑	❑
Herpes oral	❑	❑
Herpes genital	❑	❑
Anemia	❑	❑
Jaundice	❑	❑
Gallbladder disease	❑	❑
Epilepsy	❑	❑
Migraine headaches	❑	❑
Tuberculosis	❑	❑
Phlebitis or blood clots	❑	❑
Cancer	❑	❑
High or low blood pressure	❑	❑
Anxiety/Depression/Bipolar	❑	❑

3) DO YOU NOW HAVE OR HAVE YOU EVER HAD:	No	Yes
Any eye disease, injury, impaired sight	❑	❑
Any ear disease, injury, impaired hearing	❑	❑
Any trouble with nose, sinuses, mouth, throat, allergies	❑	❑
Any head injury, fainting spells, convulsions	❑	❑
Frequent or severe headaches	❑	❑
Skin disease	❑	❑
Chronic or frequent cough	❑	❑
Chest pain or spitting up of blood	❑	❑
Night sweats	❑	❑
Shortness of breath	❑	❑
Swelling of hands, feet or ankles	❑	❑
Varicose veins	❑	❑
Kidney or bladder disease	❑	❑
Indigestion, stomach trouble, ulcer or reflux	❑	❑
Rectal bleeding, constipation or diarrhea	❑	❑
Loss of urine with cough or sneeze	❑	❑
Thyroid trouble	❑	❑
Diabetes	❑	❑

Breast surgery ______________________________

GYN surgery ______________________________

Trauma/Domestic Violence ______________________________

____

Relevant Family History ______________________________

____

Surgery - what, when, where –

____

____

____

Hospitalizations - what, when, where –

____

____

4) Social History:

Alcoholic Beverages ❑ Never ❑ Moderate ❑ Daily Cigarettes _______packs per day.

Street Drugs ❑ Yes ❑ No

Reviewed by______________________________

continued

PREGNANCY
OB/GYN HISTORY

5) MENSTRUAL HISTORY:

Age at onset___________ Regular: ❑ No ❑ Yes Cycle:___________Days (ie. 28-30) Usual duration of flow:___________ Days
Flow: ❑ Light ❑ Mod ❑ Heavy Pains or Cramps ❑ No ❑ Yes Date of last period ___________________________
Painful intercourse? ❑ No ❑ Yes Bleeding after intercourse? ❑ No ❑ Yes Date of last Pap Test: ________________________
Vaginal discharge: ❑ No ❑ Yes ____ History of Abnormal: ❑ No ❑ Yes

6) Birth Control Methods: ____
Sexual problems No ❑ Yes ❑ ____

7) LIST PREGNANCIES (INCLUDE MISCARRIAGES)

YEAR	BIRTH WEIGHT	SEX	HOURS OF LABOR	ANESTHESIA	COMPLICATIONS

Number of adopted children: ____

8)

GENETIC SCREENING
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE $\geq$ 35 YEARS			12. MENTAL RETARDATION/AUTISM		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR			13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENITAL HEART DEFECT			14. MATERNAL METABOLIC DISORDER (EG. INSULIN-DEPENDENT DIABETES, PKU)		
5. DOWN SYNDROME			15. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH					
7. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			16. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. CLOTTING PROBLEMS/FACTOR V			17. MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MESTRUAL PERIOD		
9. MUSCULAR DYSTROPHY					
10. CYSTIC FIBROSIS			IF YES, AGENT(S):		
11. HUNTINGTON CHOREA			18. X-RAY EXPOSURE		

9) IMMUNIZATIONS:

Primary Date	Booster
MMR (Mumps, Measles, Rubella)	
TETANUS	
HEPATITIS A	
HEPATITIS B	
CHICKEN POX	
PERTUSSIS	
HPV	

Transfusions No ❑ Yes ❑ How many___________________ Blood type:_________________

What medicines are you now on and dose: 1. ____

2. ____3____

Allergies to medicines: ____

____

Reviewed by_________________________________