## OBSTETRICAL MEDICAL HISTORY Patient Name \_\_\_ \_\_\_\_\_ Date Form Completed \_\_\_ PER

SO.	NAL HEALTH HISTORY									
1.	Are you allergic to any r	nedications?		☐ Yes ☐ No	PHYSICIAN NOTES	•				
	If yes, please list:									
2.	Please mark any condit	ion that you have								
		Cancer	Fibromyalgia	□ HIV						
	☐ Asthma ☐ Bladder or Kidney ☐	Chicken Pox	<ul><li>☐ Group B Strep</li><li>☐ Headaches</li></ul>	☐ Hyperactivity ☐ Kidney Disease						
	Infections	Diabetes	☐ Heart Problems	☐ Migraine Headaches						
	☐ Bleeding Disorder ☐ Blood Disease	Emotional Disorders	☐ Hepatitis	☐ Thyroid Disorder						
		Epilepsy	☐ Herpes ☐ High Blood Pressu							
	Describe, if needed:	- , ,								
	Please indicate any ope									
4.	Please describe any health problems or symptoms you are having at this time:									
209	SURES AFFECTING HEAL									
1.	Do you use tobacco? [	□Yes□Nolfve	s how much ner day	?						
2.	Do you drink alcoholic	beverages? ☐ Ye	es 🗆 No. If ves. how	often?						
	What type of drink(s)?									
3.	Please list any medica	ations taken since	your last period, inc	luding over-the-counter		_				
	medications:									
4.	Have you had an influe	enza (flu) vaccine?	Yes □ No If ves	when?						
				n medication, meth, etc.):						
	FICASCIISLATIV ULDUS USE	past ( c	oodino, manjaana, par	i i i i caroation, matri, eter,						
	t									
5.	Dates last used:  Do you have a history partners or sexual exp	of blood transfu	sion, intravenous dri bi-sexual male, expe							
5. 6.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any	of blood transfu osure to a gay or other reason to b	sion, intravenous dr bi-sexual male, exp elieve you may have	ug use, multiple sexual osure to an intravenous been exposed to AIDS?						
<ul><li>5.</li><li>6.</li><li>7.</li></ul>	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem	of blood transfurosure to a gay or other reason to be	sion, intravenous dribi-sexual male, expelieve you may have	ug use, multiple sexual osure to an intravenous been exposed to AIDS?	-					
<ul><li>5.</li><li>6.</li><li>7.</li></ul>	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem	of blood transfurosure to a gay or other reason to be nicals or radiation	sion, intravenous dribi-sexual male, expedieve you may have	ug use, multiple sexual osure to an intravenous been exposed to AIDS?						
<ul><li>5.</li><li>6.</li><li>7.</li><li>8.</li></ul>	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special dilf yes, please describe:	of blood transfurosure to a gay or other reason to be nicals or radiation	sion, intravenous dribi-sexual male, expelieve you may have	ug use, multiple sexual osure to an intravenous been exposed to AIDS?						
<ul><li>5.</li><li>6.</li><li>7.</li><li>8.</li></ul>	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem	of blood transfurosure to a gay or other reason to be nicals or radiation	sion, intravenous dribi-sexual male, expelieve you may have	ug use, multiple sexual osure to an intravenous been exposed to AIDS?						
<ul><li>5.</li><li>6.</li><li>7.</li><li>8.</li><li>9.</li></ul>	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe:  Do you have cats?	of blood transful osure to a gay or other reason to be nicals or radiation	sion, intravenous dribi-sexual male, expelieve you may have	ug use, multiple sexual osure to an intravenous been exposed to AIDS?						
5. 6. 7. 8.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?	of blood transful osure to a gay or other reason to be nicals or radiation let?	sion, intravenous dribi-sexual male, expelieve you may have	ug use, multiple sexual osure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe:  Do you have cats?	y of blood transful osure to a gay or other reason to be nicals or radiation iet?	sion, intravenous dribi-sexual male, expelieve you may have (i.e. x-rays)?	ug use, multiple sexual psure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. 3YI	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe:  Do you have cats?	y of blood transful to a gay or other reason to be nicals or radiation iet?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual osure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last Par	of blood transfurosure to a gay or other reason to be nicals or radiation set?	sion, intravenous dribi-sexual male, expelieve you may have (i.e. x-rays)?	ug use, multiple sexual psure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. <b>3YI</b> 1.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last Pal Pap Smear?  Yes	of blood transfurosure to a gay or other reason to be nicals or radiation liet?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual osure to an intravenous been exposed to AIDS?  Yes No Yes No Yes No						
5. 6. 7. 8. 9. GYN 1.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS  When was your last mer  When was your last Pap Pap Smear?  Yes  What was the diagnosis  What was done?	of blood transfurosure to a gay or other reason to be nicals or radiation et?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual osure to an intravenous been exposed to AIDS?  Yes No Yes No Yes No						
5. 6. 7. 8. 9.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS  When was your last mer  When was your last Pap Pap Smear?  Yes  What was the diagnosis  What was done?	y of blood transfurosure to a gay or other reason to be nicals or radiation set?  TORY nstrual cycle (perion Smear? No If yes, when? ?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual osure to an infravenous been exposed to AIDS?						
5. 6. 7. 9. 9. 1. 2.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last mer when was your last Pap Pap Smear?   Yes  What was the diagnosis What was done?  Have you ever had gond If yes, when and where	r of blood transfurosure to a gay or other reason to be nicals or radiation set?  TORY nstrual cycle (perion Smear? No If yes, when? Printea, chlamydia were you treated?	sion, intravenous dribi-sexual male, expelieve you may have (i.e. x-rays)?	ug use, multiple sexual osure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. 1. 2.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last mer When was your last mer When was your last mer What was the diagnosis What was done?  Have you ever had gond If yes, when and where Have you ever had herp	r of blood transfurosure to a gay or other reason to be nicals or radiation let?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual psure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. 3YII. 3. 11. 5.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last mer When was your last mer When was your last mer What was the diagnosis What was done?  Have you ever had gond If yes, when and where Have you ever had herp	r of blood transfurosure to a gay or other reason to be nicals or radiation set?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual psure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. SYN 1. 5. 6. 6.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last mer When was your last mer When was your last Pap Pap Smear? Yes What was the diagnosis What was done?  Have you ever had gond If yes, when and where Have you ever had herp Did you receive the HPN Do you use contraceptive	r of blood transfurosure to a gay or other reason to be nicals or radiation let?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	ug use, multiple sexual psure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. 3YI 1. 5. 6. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS When was your last mer When was your last mer When was your last Pap Pap Smear? Yes What was the diagnosis What was done?  Have you ever had gond If yes, when and where Have you ever had herp Did you receive the HPN Do you use contraceptive	r of blood transfurosure to a gay or other reason to be nicals or radiation let?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	g use, multiple sexual osure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. SYN 3. 1. 5. 3.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS  When was your last mer  When was your last mer  When was your last Pap Pap Smear?   Yes   What was the diagnosis  What was done?  Have you ever had gond  If yes, when and where have you ever had herp  Did you receive the HPN  Do you use contraceptive have you had bladder of yes, what was done?  Do you have a history of	r of blood transfurosure to a gay or other reason to be nicals or radiation liet?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	g use, multiple sexual osure to an infravenous been exposed to AIDS?						
5. 6. 7. 8. 9. SYN 1. 5. 6. 7. 3. 3.	Dates last used:  Do you have a history partners or sexual exp drug user, or have any  Do you work with chem  Are you on a special di If yes, please describe: Do you have cats?  NECOLOGIC HEALTH HIS  When was your last mer  When was your last mer  When was your last Pap Pap Smear?   Yes   What was the diagnosis  What was done?  Have you ever had gond  If yes, when and where have you ever had herp  Did you receive the HPN  Do you use contraceptive have you had bladder of lives, what was done?	r of blood transfurosure to a gay or other reason to be nicals or radiation liet?	sion, intravenous dribi-sexual male, expelieve you may have  (i.e. x-rays)?	g use, multiple sexual psure to an infravenous been exposed to AIDS?						

10. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)?  11. Do you have any special needs for: Hearing:   Yes   No   Vision:   Yes   No   Language:   Yes   No   Yes   No   Language:   Yes   No   Yes   No   Yes   No   Language:   Yes   No   Yes   Yes   No   If yes, please describe:   Yes   No   Y	Patien	t Name	<u> </u>	ALLERGIES			
10. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)?  11. Do you have any special needs for: Hearing: \[ \] Yes \[ \] No \[ Vision: \[ \] Yes \[ \] No \[ Language: \] Yes \[ \] No \[ Yes \[ \] No \[ Vision: \[ \] Yes \[ \] No \[ Language: \] Yes \[ \] No \[ Yes \[ \] No \[ Institute of the baby's father had a child born with a birth defect? \[ \] Language: \[ \] Yes \[ \] No \[ If yes, please describe: \[ \] Lave either you or the baby's father have a birth defect yourselves? \[ \] If yes, please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis).  How is the affected child/person related to you?  4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? \[ \] Yes \[ \] No \[ \] Hyes, have either of you had genetic counselling? \[ \] Hyes, have either of you had chromosomal studies? \[ \] Yes \[ \] No \[ \] Hyes, have either of you had chromosomal studies? \[ \] Yes \[ \] No \[ \] Yes \[ \] No \[ \] Hyes, have you had Tay-Sach's screening tests? \[ \] Yes \[ \] No \[ \] Yes \[ \] No \[ \] Hyes, have you had Tay-Sach's screening tests? \[ \] Yes \[ \] No \[ \] Hyes, have you had Sickle Cell screening? \[ \] Yes \[ \] No \[ \] Hyes, have you had Sickle Cell screening? \[ \] Yes \[ \] No \[ \] Hyes, have you had Sickle Cell screening? \[ \] Hyes \[ \] No \[ \] Hyes, how is that person related to you? \[ \] High Blood Pressure \[ \] Yes \[ \] No \[ \] Hyes, how is that person related to you? \[ \] High Blood Pressure \[ \] Yes \[ \] No \[ \] Hyes, how is that person related to you? \[ \] Hepatitis \[ \] Yes \[ \] No \[ \] Hyes, how is that person related to you? \[ \] High Blood Pressure \[ \] Yes \[ \] No \[ \] Hyes, how is that person related to you? \[ \] High Blood Pressure \[ \]	OBST	ETRICAL MEDICAL HIST	ORY, PAGE 2				
1. Have either you or the baby's father had a child born with a birth defect?		. Do you have any religious	s or other objectio		-		
1. Have either you or the baby's father had a child born with a birth defect?	11	. Do you have any special	needs for: H	Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Language: ☐ Yes ☐ No	+		
If yes, please describe:    2. Did either you or the baby's father have a birth defect yourselves?	FAMIL	Y HISTORY & GENETIC H	HISTORY				
If yes, please describe:  3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis).  How is the affected child/person related to you?  4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)?   Yes   Ne   Yes, have either of you had denomosomal studies?   Yes   Ne   Yes, have either of you had chromosomal studies?   Yes   Ne   Ye	1.	· ·	-		□Yes	□No	
ample, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis).  How is the affected child/person related to you?  4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)?   Yes   N   If yes, have either of you had genetic counselling?   Yes   N   If yes, have either of you had chromosomal studies?   Yes   N   Where and results:   Yes   N   N   If yes, have you had Tay-Sachs screening tests?   Yes   N   Date:   Result:   African-American?   Yes   N   N   If yes, have you had Sickle Cell screening?   Yes   N   Date:   Result:   Result:   Yes   N   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   If yes, how is that person related to you?   High Blood Pressure   Yes   N   If yes, how is that person related to you?   Twins/multiple gestation   Yes   N   If yes, how is that person related to you?   Twins/multiple gestation   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person related to you?   Yes   N   If yes, how is that person relat	2.				.□Yes -	□No	
How is the affected child/person related to you?  4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)?	3.	ample, mental retardatio	n, birth defects,	deformities, or inherited diseases like hemophilia, muscular dystrophy or			
If yes, have either of you had genetic counselling?		How is the affected ch	nild/person related	··	-		
or the baby's father is of one of these backgrounds:  Jewish ancestry?	4.	If yes, have either of y If yes, have either of y	ou had genetic coou	ounselling?omal studies?	.□Yes		
Date:	5.						
Date: Result:  6. Please mark if anyone in your family or the baby's father's family has:  Diabetes Yes No If yes, how is that person related to you?  Bleeding Disorder Yes No If yes, how is that person related to you?  High Blood Pressure Yes No If yes, how is that person related to you?  Cancer Yes No If yes, how is that person related to you?  Hepatitis Yes No If yes, how is that person related to you?  HIV Yes No If yes, how is that person related to you?  Twins/multiple gestation Yes No If yes, how is that person related to you?  Twins/multiple gestation Yes No If yes, how is that person related to you?  7. Please list any other concerns you have about birth defects or inherited disorders:		Jewish ancestry?	☐ Yes ☐ No			□No	
Diabetes		African-American?	☐ Yes ☐ No			□No	
Bleeding Disorder	6.	Please mark if anyone in your family or the baby's father's family has:					
High Blood Pressure			☐ Yes ☐ No				
Cancer		•		· ·			
Hepatitis		*		· · · · · · · · · · · · · · · · · · ·			
HIV							
Twins/multiple gestation							
8. Will you be 35 or older at the time the baby is born?			□Yes □No				
8. Will you be 35 or older at the time the baby is born?	7.	Please list any other cond	cerns you have al	pout birth defects or inherited disorders:			
9. Will the father be 50 or older?					-		
Patient Signature Print Name Date	8.	Will you be 35 or older at	the time the baby	y is born?	□ Yes	□N	
	9.	Will the father be 50 or ol	der?		□Yes	□N	
Dhysician Natas		Patient Signature		Print Name Date	-		
Physician Notes.	PI	nysician Notes:					
		<del></del>					