OBSTETRICAL MEDICAL HISTORY

Patient Name _____ Date Form Completed _____

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list: _____
2. Please mark any condition that you have or have had in the past:

☐ Arthritis or Lupus	☐ Cancer	☐ Fibromyalgia	☐ HIV
☐ Asthma	☐ Chicken Pox	☐ Group B Strep	☐ Hyperactivity
☐ Bladder or Kidney Infections	☐ Depression	☐ Headaches	☐ Kidney Disease
☐ Bleeding Disorder	☐ Diabetes	☐ Heart Problems	☐ Migraine Headaches
☐ Blood Disease	☐ Emotional Disorders	☐ Hepatitis	☐ Thyroid Disorder
☐ Bowel Disease	☐ Epilepsy	☐ Herpes	☐ Other
		☐ High Blood Pressure	

   Describe, if needed: _____
3. Please indicate any operations or surgery you have had: _____
4. Please describe any health problems or symptoms you are having at this time:

EXPOSURES AFFECTING HEALTH

1. Do you use tobacco? ☐ Yes ☐ No If yes, how much per day? _____
2. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often? _____
   What type of drink(s)? _____
3. Please list any medications taken since your last period, including over-the-counter medications: _____
4. Have you had an influenza (flu) vaccine? ☐ Yes ☐ No If yes, when? _____
5. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.):
   Dates last used: _____
6. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?
7. Do you work with chemicals or radiation (i.e. x-rays)? ☐ Yes ☐ No
8. Are you on a special diet? ☐ Yes ☐ No
   If yes, please describe: _____
9. Do you have cats? ☐ Yes ☐ No

GYNECOLOGIC HEALTH HISTORY

1. When was your last menstrual cycle (period)? _____
2. When was your last Pap Smear? _____ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No If yes, when? _____
   What was the diagnosis? _____
   What was done? _____
3. Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease? ☐ Yes ☐ No
   If yes, when and where were you treated? _____
4. Have you ever had herpes? ☐ Yes ☐ No
5. Did you receive the HPV vaccine (Gardasil)? ☐ Yes ☐ No
6. Do you use contraceptives? ☐ Yes ☐ No If yes, what type: _____
7. Have you had bladder or kidney infections? ☐ Yes ☐ No
   If yes, what was done? _____
8. Do you have a history of infertility? ☐ Yes ☐ No If yes, please describe when and treatment received: _____
9. Please list any other concerns you have related to your past health history:

PHYSICIAN NOTES

_____ Patient Signature _____ Print Name _____ Date

Patient Name _____ **ALLERGIES** _____

OBSTETRICAL MEDICAL HISTORY, PAGE 2

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

FAMILY HISTORY & GENETIC HISTORY

1. Have either you or the baby's father had a child born with a birth defect? ..... ☐ Yes ☐ No
   If yes, please describe: _____

2. Did either you or the baby's father have a birth defect yourselves? ..... ☐ Yes ☐ No
   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 ☐ No
   If yes, have either of you had genetic counselling? ..... ☐ Yes ☐ No
   If yes, have either of you had chromosomal studies? ..... ☐ Yes ☐ No
   Where and results: _____

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

   Jewish ancestry? ☐ Yes ☐ No If yes, have you had Tay-Sachs screening tests? ..... ☐ Yes ☐ No
   Date: _____ Result: _____

   African-American? ☐ Yes ☐ No If yes, have you had Sickle Cell screening? ..... ☐ Yes ☐ No
   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 pregnancy	☐ 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:
   _____
   _____

8. Will you be 35 or older at the time the baby is born? ..... ☐ Yes ☐ No

9. Will the father be 50 or older? ..... ☐ Yes ☐ No

_____ _____ _____
Patient Signature Print Name Date

Physician Notes: _____
_____
_____
_____