

# 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

1.  Yes  No Are you allergic to any medications? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_
2. 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 Williebrand'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: \_\_\_\_\_  
\_\_\_\_\_
3. Please indicate any surgery that you have had: \_\_\_\_\_  
\_\_\_\_\_
4. Please describe any health problems or symptoms that you are having at this time: \_\_\_\_\_  
\_\_\_\_\_
5.  Yes  No Do you or any family member have a history of problems with anesthesia?  
If yes, please describe: \_\_\_\_\_
6.  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

1.  Yes  No Have you or has the baby's father had a child born with a birth defect?  
If yes, please describe: \_\_\_\_\_
2.  Yes  No Did either you or the baby's father have a birth defect?  
If yes, please describe: \_\_\_\_\_
3. 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? \_\_\_\_\_
4.  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? \_\_\_\_\_
5. 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:
- Yes  No Eastern Europe Jewish ancestry  
If yes, have you had Tay-Sachs screening tests?  Yes  No  
If yes, have you had a Canavan screening test?  Yes  No  
Date \_\_\_\_\_ Result \_\_\_\_\_
- Yes  No African American  
If yes, have you had sickle cell screening?  Yes  No
- Yes  No European Ancestry  
If yes, have you had cystic fibrosis screening?  Yes  No
- Yes  No Mediterranean Ancestry or Southeast Asian Ancestry  
If yes, have you had screening for inherited forms of anemia such as thaissemia?  Yes  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 \_\_\_\_\_