# OBSTETRIC MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

## PERSONAL HEALTH HISTORY

☐Yes ☐No Are you allergic to any medications? If yes, please list:

_____
_____
_____

Please mark any condition that you have or have had in the past:

☐ Cancer ☐ HIV/AIDS ☐ Hepatitis ☐ Frequent infections

☐ Sexually transmitted diseases ☐ Herpes ☐ Recurrent urinary tract infections

☐ Epilepsy ☐ Headaches ☐ Depression/Anxiety ☐ Eating disorder

☐ Heart Disease ☐ Kidney disease ☐ High Blood Pressure ☐ Arthritis or lupus

☐ Diabetes ☐ Thyroid disorder ☐ Bowel disease ☐ Asthma

☐ von Willebrand's disease or other bleeding disorders ☐ Blood clotting disorder (eg. phlebitis)

Describe if needed:

_____
_____
_____

Please indicate any surgery that you have had:

_____
_____
_____

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

_____
_____
_____

☐Yes ☐No Do you or any family member have a history of problems with anesthesia? If yes, please describe:

_____
_____
_____

☐Yes ☐No Do you have any religious objections to any form of medical treatment (eg. refusal of blood transfusion)? If yes, please describe:

_____
_____
_____

## EXPOSURES AFFECTING HEALTH

□Yes □No Do you smoke cigarettes? If yes, how many packs per day/week/month: _____

□Yes □No Do you drink alcoholic beverages?
If yes, how often? _____
What type of drinks? _____

Please list ay medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____
_____
_____

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

□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 sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)?

□Yes □No Are you ever exposed to chemicals or radiation? If yes, please describe:
_____

□Yes □No Are you on a restricted diet? If yes, please describe: _____

## GYNECOLOGIC HEALTH HISTORY

When was your last Pap test? _____

□Yes □No Have you ever had an abnormal Pap test? If yes, when and how were you treated? _____
_____
_____

□Yes □No Have you ever had gonorrhea□, chlamydia□, or pelvic inflammatory disease□ ?
If yes, when, how, and where were you treated? _____
_____

□Yes □No Have you ever had herpes? If yes, how often do you have outbreaks? _____
□Yes □No Have you ever had syphilis? If yes, when, how, and where were you treated? _____
_____

□Yes □No Have you ever had an IUD (intrauterine device) for contraception? If yes, when: _____
Did you have any problem with the IUD? If yes, please describe: _____
_____

□Yes □No Have you been treated for infertility? If yes, please describe when and treatment received:
_____

□Yes □No Do you have any concerns related to your past health history? If yes, please list:
_____

## FAMILY HISTORY & GENETIC SCREENING

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

□Yes □No Do either you or the baby's father have a birth defect? If yes, please describe:
_____

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?
_____
_____
_____

□Yes □No Do either you or 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? _____
_____

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or if 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
Date _____ Result _____

□Yes □No European Ancestry
If yes, have you had cystic fibrosis screening? □Yes □No
Date _____ Result _____

□Yes □No Mediterranean ancestry or Southwest Asian ancestry
If yes, have you had screening for inherited forms of anemia such as thalassemia? □Yes □No
Date _____ Result _____

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

□Yes □No Will you be 35 years or older at the time the baby is born?

□Yes □No Will the father be 50 years or older?

| PSYCHOSOCIAL SCREENING | |
|---|---|
| □Yes □No | Do you have any problems (job, transportation, etc.) that prevent you from keeping health care appointments? |
| □Yes □No | Do you feel unsafe where you live? |
| □Yes □No | In the past 2 months, have you used any form of tobacco? |
| □Yes □No | In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)? |
| □Yes □No | In the past year, have you been threatened, hit, slapped, or kicked by anyone you know? |
| □Yes □No | Has anyone forced you to perform any sexual act that you did not want to do? |
| | On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High |
| | How many times have you moved in the past 12 months? _____ |
| | If you could change the timing of this pregnancy, would you want it:<br>□ Earlier □ Later □ Not at all □ No change |

_____
Patient Signature

_____
Print Name

_____
Date