OBSTETRIC MEDICAL HISTORY

Patient Name: _____ Date Form Completed: _____

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL MEDICAL 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:

☐ Cancer	☐ HIV/AIDS	☐ Diabetes
☐ Epilepsy	☐ Thyroid Disease	☐ Eating Disorder
☐ Heart Disease	☐ Headaches	☐ Depression
☐ High Blood Pressure	☐ Arthritis or Lupus	☐ Asthma
☐ Kidney Disease	☐ Frequent Infections	☐ Anemia
☐ Hepatitis	☐ Bowel Disease	☐ Herpes
☐ von Willebrand's Disease or Other Bleeding Disorder		☐ Sexually Transmitted Diseases
☐ Blood Clotting Disorder (e.g., Phlebitis)		☐ Recurrent Urinary Tract Infections

   Describe, if needed: _____
   _____
   _____

3. Please indicate any surgery or hospitalization 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 a 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 (e.g., refusal of blood transfusion)?
   If yes, please list: _____
   _____
   _____
   _____

EXPOSURES AFFECTING HEALTH

1. ☐ Yes ☐ No Do you smoke cigarettes? If former smoker, when did you quit? _____
   If yes, how many packs per day? _____
2. ☐ Yes ☐ No Do you drink alcoholic beverages now or did you before you became pregnant? (1.5 oz spirits = 12 oz beer)
   If yes, how often? _____
   What type of drinks? _____
3. Please list any medications taken since your last period, including perscriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____
   _____
4. Please list any illicit or recreational drugs used since your last period (e.g., cocaine, marijuana):_____
   _____
5. ☐ Yes ☐ No Do you have any reason to believe you may have been exposed to AIDS (e.g., a history of blood transfusions, intravenous drug use, multiple sexual 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 (e.g., 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 ☐ Pelvic Inflammatory Disease
   If yes, how, when 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 Syphillis?
   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 what treatment received: _____
   _____
6. ☐ Yes ☐ No Do you have any concerns related to your past health history?
   If yes, please list: _____
   _____

FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

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

3. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?
   If yes, please describe: _____

4 Please describe any abnormalities that have occurred in children of your family or the baby's father's family (e.g., mental retardation, birth defects, early infant death, deformities, or inherited diseases such as hemophilia, muscular dystrophy or cystic fibrosis):

_____

_____

_____

How is this child related to you? _____

5. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?
   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? _____

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

   ☐ Yes ☐ No **Eastern European Jewish (Ashkenazi) ancestry**
   If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No
   If yes, have you had a Canavan screening test? ☐ Yes ☐ No
   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No
   If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No
   Date and results: _____

   ☐ Yes ☐ No **African-American ancestry**
   If yes, have you had sickle cell screening? ☐ Yes ☐ No
   Date and results: _____

   ☐ Yes ☐ No **European ancestry and Eastern European Jewish (Ashkenazi) ancestry**
   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No
   Date and results: _____

   ☐ Yes ☐ No **Mediterranean ancestry or Southeast Asian ancestry**
   If yes, have you had screening for inherited forms of thalassemia? ☐ Yes ☐ No
   Date and results: _____

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

   _____

   _____

   _____

   _____

8. ☐ Yes ☐ No Do you want to have a Down Syndrome risk assessment?

9. ☐ Yes ☐ No Is the baby's father 50 years or older?

PSYCHOSOCIAL SCREENING

1. ☐ Yes ☐ No Do you have any problems (job, transportation, etc.) that prevent you from keeping your healthcare appointments?
2. ☐ Yes ☐ No Do you feel unsafe where you live?
3. ☐ Yes ☐ No Are you exposed to second-hand smoke?
4. ☐ Yes ☐ No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No Has anyone forced you to perform any sexual act that you did not want to do?
7. On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
8. How many times have you moved in the past 12 months? _____

_____
Patient Signature

_____
Print Name

_____
Date