

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 HEALTH HISTORY																									
1.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> HIV/AIDS</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Thyroid disorder</td> <td><input type="checkbox"/> Eating disorder</td> </tr> <tr> <td><input type="checkbox"/> Heart disease</td> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Depression</td> </tr> <tr> <td><input type="checkbox"/> High blood pressure</td> <td><input type="checkbox"/> Arthritis or lupus</td> <td><input type="checkbox"/> Asthma</td> </tr> <tr> <td><input type="checkbox"/> Kidney disease</td> <td><input type="checkbox"/> Frequent infections</td> <td><input type="checkbox"/> Anemia</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Bowel disease</td> <td><input type="checkbox"/> Herpes</td> </tr> <tr> <td><input type="checkbox"/> von Willebrand's disease or other bleeding disorders</td> <td colspan="2"><input type="checkbox"/> Sexually transmitted diseases</td> </tr> <tr> <td><input type="checkbox"/> Blood clotting disorder (eg, phlebitis)</td> <td colspan="2"><input type="checkbox"/> Recurrent urinary tract infections</td> </tr> </table> Describe, if needed: _____ _____ _____	<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Arthritis or lupus	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Bowel disease	<input type="checkbox"/> Herpes	<input type="checkbox"/> von Willebrand's disease or other bleeding disorders	<input type="checkbox"/> Sexually transmitted diseases		<input type="checkbox"/> Blood clotting disorder (eg, phlebitis)	<input type="checkbox"/> Recurrent urinary tract infections	
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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.	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you or any family member have a history of problems with anesthesia? If yes, please describe: _____ _____ _____ _____																								
6.	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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 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 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 (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 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: _____

FAMILY HISTORY & GENETIC SCREENING

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

2. Yes No Have you or has 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 (eg, mental retardation, birth defects, early infant death, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

How is this child/person 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, of 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 _____ Result _____

Yes No African American
If yes, have you had sickle cell screening? Yes No
Date _____ Result _____

Yes No European ancestry and Eastern European Jewish (Ashkenazi) 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 thalassemia? Yes No

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 father 50 years or older?

PSYCHOSOCIAL SCREENING*

1. Yes No Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care 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? _____

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

Patient Signature

Print Name

Date