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Thank you for answering all of the following questions. Your health is important to us. Congratulations!

OBSTETRICS PATIENT HISTORY FORM

TODAY'S DATE _____ Your age_____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First)_____ (M.I.) _____

Your spouse/partner's full name _____

REFERRED HERE BY _____

1. CURRENT PREGNANCY

What was the FIRST day of the last menstrual period? _____ Is this date definite? (Y/N) _____

Cycles regular? (Y/N) _____ Cycle length (avg=28 days) _____ Date of first pos. preg. test _____

Conception (check one): _____normal Date of conception? _____ ____ IUI (date_____)

___IVF fresh cycle (date of egg retrieval _____) ____IVF frozen embryo (Date of embryo transfer _____)

What was your weight just before becoming pregnant? _____ What is your height? _____

When was your last pap smear? _____By whom? _____ Was it normal? YES NO

2. PAST PREGNANCY DETAILS

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Date of Delivery	# weeks at Delivery	Length of Labor	Birth Wght.	M F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location

3. PATIENT MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate)

X if YES	Condition	Comments
	1. Diabetes (type 1, type 2 or previous gestational diabetes). Any medication taken?	
	2. High Blood Pressure (hypertension now or in the past or with a prior pregnancy):	
	3. Heart Disease (fainting, heart murmurs, abnormal rate or rhythm, prior heart attack, abnormal valves):	
	4. Autoimmune Disorder (Lupus, Rheumatoid Arthritis, Fibromyalgia or other related conditions):	
	5. Kidney Disease or Urinary Tract Infections (UTI) (recurrent UTI, kidney stones):	
	6. Seizure Disorder or Neurologic Disease (migraines, epilepsy, history of TIA or stroke):	
	7. Mental Health Condition (includes anxiety or panic attacks, OCD, bipolar disorder, eating disorder):	
	8. History of Depression or Postpartum Depression (mild or severe, suicide attempts, hospitalization ever):	
	9. Gastrointestinal or Liver Disease (irritable bowel syndrome [IBS], Crohn's Disease, Ulcerative Colitis,	
	10. Varicose Veins or Blood Clots in Veins (pulmonary embolism, DVT – deep vein thrombosis):	
	11. Thyroid Disease (under or over active thyroid, thyroid cancer or radiation):	
	12. Domestic Violence (now or ever in the past):	
	13. History of Blood Disorders or Transfusion (anemia, blood clotting problem, transfusion ever):	
	14. Smoking History (current or former smoker):	
	15. Alcohol Use History (current or past use or abuse of alcohol):	
	16. Illicit or Recreational Drug Use History (current or past use or abuse):	
	17. Rh Disease or Rh Negative	
	18. Lung Disease (asthma, chronic bronchitis, TB):	
	19. Seasonal Allergies (hay fever, asthma):	
	21. Breast Disease or Breast Surgery (implants above the muscle, under the muscle, breast reduction):	
	23. Complications of Anesthesia (describe):	
	25. History of Abnormal Pap Smear (any treatments such as freezing, LEEP or cone biopsy and when):	
	26. History of Uterine Abnormality (double uterus, unicornuate uterus):	
	27. History of Infertility or IVF, IUI, insems?	
	28. Low Back Problems or Back Surgery?	

*Note – some numbers are skipped due to this data being entered into the EMR

4. SURGERY or HOSPITAL ADMISSIONS

Surgery or Hospital Admission - Details	Year

5. SYMPTOMS SINCE BECOMING PREGNANT

(Are you currently experiencing any of the following symptoms?)
(If so, please indicate with an X)

General
_____ Fatigue or Weakness
_____ Fever, Chills or Sweats
_____ Loss of Appetite

Eyes, Ears, Nose and Throat
_____ Nose Bleeds
_____ Sore Throat
_____ Vision or Hearing Changes

Breasts
_____ Breast Lump
_____ Breast Pain or Tenderness
_____ Nipple Discharge (other than white)

Cardiovascular
_____ Chest Pain
_____ Irregular Heartbeat or Palpitations

Respiratory
_____ Chronic Cough
_____ Shortness of Breath
_____ Wheezing

Gastrointestinal
_____ Diarrhea (watery stool)
_____ Heartburn
_____ Nausea or Vomiting
_____ Severe Constipation

Urinary
_____ Burning with Urination
_____ Leakage of Urine
_____ Waking at night 2 or more times

Skin
_____ Itching
_____ Moles or Sores
_____ Rash

Neurologic
_____ Dizziness
_____Headaches
_____ Migraines
_____ Memory Problems

Musculoskeletal
_____ Joint Pain (Back, Knee, Wrist, Hip)
_____ Joint Swelling
_____ Muscle Cramping or Pain

Psychological
_____ Anxiety, Worries, Stress (Excessive)
_____ Depressed
_____ Feeling Out of Control

Comments or Additional Symptoms Not Listed Above?

_____

_____

_____

6. GENETIC SCREENING

(If you or **ANY** close relative of yours - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please CIRCLE YES)

1. IS PATIENT GOING TO BE AGE 35 BY THE DUE DATE?	YES NO
2. HISTORY of THALASSEMIA or HEMOGLOBIN DISORDER	YES NO
3. HISTORY of NEURAL TUBE DEFECT (spina bifida)	YES NO
4. HISTORY of CONGENITAL HEART DEFECT	YES NO
5. HISTORY of DOWN SYNDROME	YES NO
6. &7. IS THE MOTHER OR FATHER OF THE BABY ASHKENAZI JEWISH or CAJUN? If yes, has any genetic testing been done?	YES NO Yes No
8. HISTORY of SICKLE-CELL ANEMIA or SICKLE-TRAIT	YES NO
9. HISTORY of HEMOPHILIA	YES NO
10. HISTORY of MUSCULAR DYSTROPHY	YES NO
11. A. HISTORY of CYSTIC FIBROSIS B. IS THE MOTHER or THE FATHER OF THE BABY CAUCASIAN/EUROPEAN?	YES NO YES NO
12. HISTORY of HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA)	YES NO
13. HISTORY of MENTAL RETARDATION If yes, was testing for Fragile X chromosome done?	YES NO Yes No
14. HISTORY of ANY INHERITABLE GENETIC SYNDROME or ANY BIRTH DEFECTS	YES NO
15. HISTORY of MATERNAL PKU OR OTHER METABOLIC SYNDROME	YES NO
16. PATIENT OR BABY'S FATHER HAD A CHILD WITH ANY BIRTH DEFECTS	YES NO
17. HISTORY OF STILLBIRTH OR 2 OR MORE MISCARRIAGES	YES NO
18. ANY HISTORY OF ILLICIT DRUG USE SINCE LAST MENSTRUAL PERIOD	YES NO

7. PRESCRIPTION MEDICATIONS YOU ARE TAKING

List name of medication, dose, and reason

8. DRUG STORE MEDICATION, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

List name of product and dosage

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____ Fax # _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

Pt Name: _____

ALLERGIES (circle choices)

Do you have any known allergies? NO ALLERGIES Allergic to Latex? YES NO

If yes, please list all allergies and your allergic reaction

Allergic to	Reaction

9. INFECTION HISTORY

1. DO YOU LIVE WITH SOMEONE WHO MIGHT HAVE TUBERCULOSIS?	YES NO
2. DO YOU or YOUR PARTNER HAVE A HISTORY OF **GENITAL** HERPES?	YES NO
3. HAVE YOU HAD A SKIN RASH or VIRAL ILLNESS SINCE YOUR LAST PERIOD?	YES NO
4. HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS B OR C ?	YES NO
5. HAVE YOU EVER HAD GONORRHEA, SYPHYLLIS, CHLAMYDIA, HIV or VENEREAL WARTS? (circle any that apply)	YES NO
6. DO YOU OR YOUR PARTNER HAVE A HISTORY OF A BLOOD TRANSFUSION OR A HISTORY OF IV DRUG USE?	YES NO

10. FAMILY MEDICAL HISTORY

*(If **ANY** close relative of yours - such as maternal and/or paternal grandparents, parents, brothers, and sisters – has EVER HAD or CURRENTLY HAS any of the problems listed below.*

CONDITION	Please CIRCLE CONDITION and indicate who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, STROKE	
3. TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE	
4. BREAST DISEASE, BREAST CANCER	
5. STOMACH, GI or COLON DISEASE or CANCER	
6. KIDNEY DISEASE, KIDNEY STONES	
7. GYN DISEASES, OVARIAN CANCER, UTERINE FIBROIDS	
8. MUSCULOSKELETAL DISEASE, OSTEOPOROSIS	
9. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
10. SEVERE DEPRESSION or OTHER PSYCHIATRIC CONDITION	
11. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
12. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
13. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	
14. ANY TYPE of CANCER or MALIGNANT TUMORS	

11. ADDITIONAL PREGNANCY ISSUES

1. It is now advised to screen all pregnant women for the HIV virus. This will be added to your initial prenatal labs unless you decline	YES	NO	TALK TO ME
2. Have you heard about Nuchal Translucency testing for Down Syndrome? (We will discuss this during your first visits.)	YES	NO	MAYBE
3. Have you heard about the MaterniT21 test for fetal DNA in the mother's bloodstream? If you are 34 or over, you might be a candidate	YES	NO	MAYBE
4. Do you get 3 servings per day of dairy products (milk, yogurt, cheese)? If not, we advise a daily Calcium Supplement (like CitraCal) with Vit D	YES	NO	
5. Do you own any cats? If so, it is advised that pregnant women not change the cat litter	YES	NO	
6. Are there any known or suspected hazards in your workplace? What is your occupation? _____	YES	NO	MAYBE
7. Do you have plane trips planned during this pregnancy? If so, we generally advise not flying after 32 weeks gestational age	YES	NO	MAYBE
8. In the past year, have you been threatened, hit, slapped or kicked by anyone you know or do you feel unsafe where you live?	YES	NO	TALK TO ME
9. Do you use a seat belt 100% of the time while driving?	YES	NO	
10. Are you considering having a tubal ligation (permanent sterilization)?	YES	NO	MAYBE
11. If you have a boy, do you want him circumcised?	YES	NO	MAYBE
12. Have you ever had chicken pox? If not, have you been vaccinated or have you already tested immune?	YES YES	NO NO	MAYBE
13. Have you ever tested positive for Vaginal Strep B or Group B Strep?	YES	NO	MAYBE
14. Do you plan to save the baby's umbilical cord blood at the time of delivery or would you like more information about this?	YES	NO	MAYBE
15. If you already have a Pediatrician, please enter their name. Is this doctor on staff at Huntington Hospital?	Dr. _____ YES	NO	MAYBE
16. Please see our OB guide on the web at: www.pasadenapregnancy.com			

It is not necessary to have made all of the above decisions yet.
We will discuss all pregnancy issues and your concerns at your consultation and throughout your pregnancy.
The above list is to help you as you begin to explore some of these issues

Notes or Questions for the Doctor: _____

_____

_____

_____

_____

_____

_____

_____

Revised February 2014

Pt Name: _____