

**OBSTETRICAL MEDICAL HISTORY**

Patient Name \_\_\_\_\_ Date Form Completed \_\_\_\_\_

**PHYSICIAN NOTES**

**PERSONAL HEALTH HISTORY**

1. Are you allergic to any medications? .....  Yes  No  
If yes, please list: \_\_\_\_\_

2. Please mark any condition that you have or have had in the past:  
 Arthritis or Lupus     Cancer     Fibromyalgia     HIV  
 Asthma     Chicken Pox     Group B Strep     Hyperactivity  
 Bladder or Kidney Infections     Depression     Headaches     Kidney Disease  
 Bleeding Disorder     Diabetes     Heart Problems     Migraine Headaches  
 Blood Disease     Emotional Disorders     Hepatitis     Thyroid Disorder  
 Bowel Disease     Epilepsy     Herpes     Other  
 High Blood Pressure

Describe, if needed: \_\_\_\_\_

3. Please indicate any operations or surgery you have had: \_\_\_\_\_

4. Please describe any health problems or symptoms you are having at this time:  
\_\_\_\_\_  
\_\_\_\_\_

**EXPOSURES AFFECTING HEALTH**

1. Do you use tobacco?  Yes  No If yes, how much per day? \_\_\_\_\_

2. Do you drink alcoholic beverages?  Yes  No If yes, how often? \_\_\_\_\_  
What type of drink(s)? \_\_\_\_\_

3. Please list any medications taken since your last period, including over-the-counter medications: \_\_\_\_\_

4. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.):  
\_\_\_\_\_  
Dates last used: \_\_\_\_\_

5. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?  
\_\_\_\_\_

6. Do you work with chemicals or radiation (i.e. x-rays)? .....  Yes  No

7. Are you on a special diet?.....  Yes  No  
If yes, please describe. \_\_\_\_\_

**GYNECOLOGIC HEALTH HISTORY**

1. When was your last Pap Smear? \_\_\_\_\_ Have you ever had an abnormal Pap Smear?  Yes  No If yes, when? \_\_\_\_\_  
What was the diagnosis? \_\_\_\_\_  
What was done? \_\_\_\_\_

2. Have you ever had gonorrhea, Chlamydia or pelvic inflammatory disease?  Yes  No  
If yes, when and where were you treated? \_\_\_\_\_

3. Have you ever had herpes?.....  Yes  No

4. Did you receive the HPV vaccine (Gardasil)?.....  Yes  No

5. Do you use contraceptives?  Yes  No If yes, what type: \_\_\_\_\_

6. Have you had bladder or kidney infections? .....  Yes  No  
If yes, what was done? \_\_\_\_\_

7. Do you have a history of infertility?  Yes  No If yes, please describe when and treatment received: \_\_\_\_\_

8. Please list any other concerns you have related to your past health history:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

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- 9. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)? \_\_\_\_\_
- 10. Do you have any special needs for:      Hearing:  Yes  No      Vision:  Yes  No      Language:  Yes  No

**FAMILY HISTORY & GENETIC HISTORY**

1. Have either you or the baby's father had a child born with a birth defect?.....  Yes  No  
If yes, please describe. \_\_\_\_\_

2. Did either you or the baby's father have a birth defect yourselves? .....  Yes  No  
If yes, please describe: \_\_\_\_\_

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). \_\_\_\_\_  
How is the affected child/person related to you? \_\_\_\_\_

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? .....  Yes  No  
If yes, have either of you had genetic counseling? .....  Yes  No  
If yes, have either of you had chromosomal studies? .....  Yes  No  
Where and results. \_\_\_\_\_

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

Jewish ancestry?       Yes  No      If yes, have you had Tay-Sachs screening tests?.....  Yes  No  
Date: \_\_\_\_\_ Result \_\_\_\_\_

African-American?       Yes  No      If yes, have you had Sickle Cell screening?.....  Yes  No  
Date: \_\_\_\_\_ Result: \_\_\_\_\_

6. Please mark if anyone in your family or the baby's father's family has:

Diabetes                       Yes  No      If yes, how is that person related to you?  
Bleeding Disorder         Yes  No      If yes, how is that person related to you?  
High Blood Pressure       Yes  No      If yes, how is that person related to you?  
Cancer                         Yes  No      If yes, how is that person related to you?  
Hepatitis                     Yes  No      If yes, how is that person related to you?  
HIV                             Yes  No      If yes, how is that person related to you?

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

- 8. Will you be 35 or older at the time the baby is born? .....  Yes  No
- 9. Will the father be 50 or older? .....  Yes  No

\_\_\_\_\_  
Patient Signature                                      Print Name                                      Date

Physician Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_