OBSTETRIC MEDICAL HISTORY

Patient name: _____
Date form completed: _____

Personal Health History

Yes	No	
☐	☐	1. Are you allergic to any medications? If yes, please list: _____
		2. Please mark any condition you have or have had in the past: ☐ Cancer ☐ HIV/AIDS ☐ Diabetes ☐ Hepatitis ☐ Epilepsy ☐ Thyroid disorder ☐ Eating disorder ☐ Bowel disease ☐ Heart disease ☐ Headaches ☐ Depression ☐ Herpes ☐ High blood pressure ☐ Arthritis or lupus ☐ Asthma ☐ Sexually transmitted disease ☐ Kidney disease ☐ Frequent infections ☐ Anemia ☐ Recurrent urinary tract infections ☐ von Wildebrand's disease or other bleeding disorder ☐ Blood clotting disorder (eg, phlebitis) 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. Do you or any family member have a history of problems with anesthesia? If yes, please describe: _____
☐	☐	6. Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)? If yes, please describe: _____

Gynecologic Health History

Yes	No	
☐	☐	1. When was your last pap test? _____ Have you ever had an abnormal pap test? If yes, when and how were you treated? _____ What was the diagnosis? _____
☐	☐	2. Have you ever had? gonorrhea ☐ chlamydia ☐ pelvic inflammatory disease ☐ If yes, when, how, and where were you treated? _____
☐	☐	3. Have you ever had herpes? If yes, how often do you have outbreaks? _____
☐	☐	4. Have you ever had syphilis? If yes, how, when, and where were you treated? _____
☐	☐	5. Have you ever used an IUD (intrauterine device) for contraception? If yes, please indicate when? _____
☐	☐	Did you ever have any problems with the IUD? If yes, please describe: _____
☐	☐	6. Have you ever been treated for infertility? If yes, please describe when and treatment received: _____
☐	☐	7. Do you have any other concerns about your past health history? If yes, please list: _____

Please continue answering questions on next page.

Psychosocial Screening

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

Exposures Affecting Health

Yes	No	
☐	☐	1. Do you smoke? If former smoker, when did you quit? _____ If yes, how many packs per day? _____
☐	☐	2. Do you drink alcoholic beverages now or did you before you became pregnant? If yes, how often? _____
		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. Do you have any reason to believe you may have been exposed to AIDS (eg, history of blood transfusion, intravenous drug use, multiple sexual partners)?
☐	☐	6. Are you ever exposed to chemicals or radiation (eg, X-rays)? If yes, please describe: _____
☐	☐	7. Are you on a restricted diet? If yes, please describe: _____

Family History & Genetic Screening

Yes	No	
		1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____
☐	☐	2. Have you or have the baby's father had a child born with a birth defect? If yes, please describe: _____
☐	☐	3. 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. Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirth)? 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: European ancestry or Eastern European Jewish (Ashkenazi) ancestry If yes, have you had any screening tests? Yes ☐ No ☐
☐	☐	African American If yes, have you had sickle cell screening? 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. Do you want to have a Down Syndrome risk assessment?