Capital Women's Care
Frederick OB/GYN Division

# FATHER OF BABY - HISTORY QUESTIONNAIRE

**To help us know your medical history, please answer these questions and bring with you when you are called back by the Medical Assistant for your appointment**

Name: _____Date:_____

Date of Birth: _____

**Do you have any children from a different relationship? YES/NO**

Race: _____ Ethnicity (circle one): Latino non-Latino Language: _____

Occupation: _____

**Medical History: Please check any that *you* have had:**

_ Asthma
_ Autoimmune disease
_ Hx of blood transfusion
_ Breast Cancer
_ Bruising/bleeding disorder
_ Stroke
_ Congenital heart disease
_ Depression
_ Diabetes
_ Drug/Alcohol Abuse
_ Fam Hx of genetic disorder
_ Exposure to Herpes
_ Genital Herpes
_ Heart Murmur
_ Hepatitis/Liver disease
_ Blood Disorder
_ High Cholesterol
_ High Blood Pressure
_ Infertility
_ Psychiatric Disease
_ Pulmonary embolism
_ Seizure Disorder
_ Thyroid Disease
_ Tuberculosis
_ STD
_ HIV/AIDS

Other:

_____

_____

_____

_____

**Tobacco Use:** _ Never _ Yes _ Former

**Over** ⟶

**Family History:**

Please indicate the family member by putting a check mark in the box. If the family member is someone other than those listed please indicate maternal or paternal (aunt, uncle, grandmother, or grandfather).

| **Diagnosis:** | **Mother** | **Father** | **Sister** | **Brother** | **Son** | **Daughter** |
|---|---|---|---|---|---|---|
| Alive and Well | | | | | | |
| Deceased (indicate cause) | | | | | | |
| Alcoholism | | | | | | |
| Asthma | | | | | | |
| Autoimmune disorder | | | | | | |
| Breast Cancer | | | | | | |
| Cervical Cancer | | | | | | |
| Coagulopathy (Blood clots) | | | | | | |
| Colon Cancer | | | | | | |
| Heart birth defect | | | | | | |
| CAD/Heart attack | | | | | | |
| Stroke | | | | | | |
| Cystic Fibrosis | | | | | | |
| Depression | | | | | | |
| Developmental delay | | | | | | |
| Diabetes | | | | | | |
| Down's Syndrome | | | | | | |
| Hemophilia-A | | | | | | |
| High Cholesterol | | | | | | |
| High Blood Pressure | | | | | | |
| Mental Illness | | | | | | |
| Mental retardation | | | | | | |
| Muscular dystrophy | | | | | | |
| Osteoporosis | | | | | | |
| Ovarian Cancer | | | | | | |
| Seizure disorder | | | | | | |
| Sickle cell disease | | | | | | |
| Spina Bifida | | | | | | |
| Thyroid disease | | | | | | |
| Other | | | | | | |

If updated please initial and date:

_____ _____

Updated Form 11/2015