

Minal Mehta, M.D. Phone: (714) 848-2383

Hind Al-Azawi, M.D. Fax: (714) 848-4083

18111 Brookhurst Street, Fountain Valley, CA 92708

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**PATIENT HISTORY**

Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_

**PREGNANCY HISTORY: PAST PREGNANCIES (LAST 6)**

| # of Pregnancies:\_\_\_\_\_\_ | # of Premature Births:\_\_\_\_\_\_ | # of Miscarriages:\_\_\_\_\_\_ | # of Induced Abortions\_\_\_\_\_\_ | # of Living Children: \_\_\_\_\_\_ |
| --- | --- | --- | --- | --- |

| # of Term Births | BornMonth/Year | Baby’sSexF/M | WeightAtBirth | Weeks PregnantTerm-40wks | HoursIn Labor | Type of Delivery | Type ofAnesthesia | Complications?yes/no |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | / |  |  lbs. oz. |  |  |  |  |  |
| 2 | / |  |  lbs. oz. |  |  |  |  |  |
| 3 | / |  |  lbs. oz. |  |  |  |  |  |
| 4 | / |  |  lbs. oz. |  |  |  |  |  |
| 5 | / |  |  lbs. oz. |  |  |  |  |  |

**MENSTRUAL HISTORY**

First Day of Last Menstrual Period \_\_\_\_/\_\_\_\_/\_\_\_\_ Abnormalities: (check all that apply)

- Menarche (Age at 1st Period):\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Excessive Bleeding \_\_\_\_ None

- Interval (# of days between periods):\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Discharge

- Length of Period:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Pain

**HOSPITALIZATIONS** (list all hospitalizations and or Surgeries)

Month / Year Illness or Operation

\_\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY** (check all that apply)

Have you or any member of your family had:

 Yes / No Yes / No

- High Cholesterol………………....Y / N - Blood Transfusion…………………………Y / N

- Heart Disease…………………….Y / N - Allergies…………………………………...Y / N

- Rheumatic Fever…………………Y / N - Breast Problems…………………………...Y / N

- High Blood Pressure……………..Y / N - Cancer……………………………………..Y / N

- Asthma…………………………...Y / N - Infertility…………………………………..Y / N

- Tuberculosis……………………...Y / N - Female or Sexual Problems……………….Y / N

- Diabetes………………………….Y / N - Chlamydia…………………………………Y / N

- Thyroid Problems………………..Y / N - Gonorrhea…………………………………Y / N

- Liver Disease…………………….Y / N - Herpes……………………………………..Y / N

- Stomach, Bowel or………………Y / N - Syphilis……………………………………Y / N

 Gallbladder Problems……………Y / N - Birth Defects or Inherited Diseases……….Y / N

- Kidney or Bladder Disorder……..Y / N - Sexual Abuse or Domestic Violence………Y / N

- AIDS (HIV)...................................Y / N - Other Medical Problems:.............................Y / N

- Hepatitis (type\_\_\_\_\_\_\_\_\_)............Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Anemia or Blood Disorder………Y / N - No Known Medical Problems…………….Y / N

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENETIC SCREENING (Includes Patient, Baby’s Father or anyone in either family with):**

Yes / No Yes / No

- Patients age is greater than 35 at time Y / N - Huntington’s Disease Y / N

 of delivery - Mental Retardation / Autism Y / N

- Thalassemia (Italian,Greek, Y / N - Other Inherited Genetic or Chromosomal Y / N

 Mediterranean, or Asian background Disorder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Neural Tube Defects Y / N - Maternal Metabolic Disorder Y / N

 (Meningomyelocele, Spina Bifida or (Eg, Type 1 Diabetes, PKU)

 Anencephaly). - Patient or Baby’s Father had a child with Y / N

- Congenital Heart Defect Y / N Birth defects not listed above\_\_\_\_\_\_\_\_\_

- Down Syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Tay-Sachs Y / N - Recurrent Pregnancy Loss, or a Stillbirth Y / N

 (Eg,Jewish,Cajun,French Canadian) - Medications (including supplements, Y / N

- Canavan Disease Y / N Vitamins, Herbs or OTC drugs, Illicit/

- Sickle Cell Disease or Trait (African) Y / N Recreational drugs, Alcohol since the

- Hemophilia or other Blood Disorders Y / N Last Menstrual Period.\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Muscular Dystrophy Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Cystic Fibrosis Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFECTION HISTORY**

 Yes / No Yes / No

- Live with someone with TB or Exposed to TB Y / N - Rash or Viral Illness since last period Y / N

- Patient or Partner has history of Genital Herpes Y / N - History of Sid, Gonorrhea, Chlamydia Y / N

 HPV or Syphilis.

**SUBSTANCE USE**

- Alcohol - Tobacco - Caffeine - Street Drugs

 Type:\_\_\_\_\_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_

 Amt/Day:\_\_\_\_\_\_\_\_\_\_ Amt/Day:\_\_\_\_\_\_\_\_\_\_ Amt/Day:\_\_\_\_\_\_\_\_\_\_ Amt/Day:\_\_\_\_\_\_\_\_\_\_

**Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_