OBSTETRICAL MEDICAL HISTORY PHYSICIAN NOTES

Patient Name _____ Date_____ _____

Please notate here if are considering pregnancy termination…… __Yes__No__Unsure_

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? YES NO
   If yes, please list reactions: _____
   Are you allergic to any foods? YES NO
   If yes, please list reactions: _____
   Are you allergic to any environmental elements? YES NO
   If yes, please list reactions: _____
2. Please circle any conditions that you have or have had in the past:

Arthritis or lupus	Depression	Hepatitis
Asthma	Diabetes	Recurrent UTI's
Blood Disease	Epilepsy	High Blood Pressure
Bowel Disease	Headaches	Kidney Disease
Chicken Pox	Heart Disease	Migraine Headaches
Thyroid Disease	Herpes	Other

   Describe, if needed: _____
   _____
3. Please indicate any surgery that you have had: _____
   _____
4. Please describe any health problem, or symptoms that you are having are having at this time: _____
   _____
5. Do you have any religious objectives to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusions)?
   _____
6. Do you have any special needs for:
   Hearing YES NO Vision YES NO Language YES NO
7. Have you ever had an influenza vaccine? Yes No If yes, when? _____
8. Do you have cats? Yes No

EXPOSURE AFFECTING HEALTH

1. Do you smoke cigarettes? YES NO If yes, how many packs a day?____
2. Do you drink alcoholic beverages? Yes No If yes, how often? _____
3. Please list any medication taken since your last period: _____
   _____
4. Please list any "recreational" drugs used since your last period (i.e. cocaine, marijuana, etc.) _____
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 reason to believe you may have been exposed to AIDS?_____
   _____
6. Please list any sources of chemical or radiation exposure that you encounter:
   _____
7. If you are on a restricted diet, please describe: _____
   _____
   _____
   _____

GYNECOLOGICAL HEALTH HISTORY

1. When was your last Pap Smear: _____ Have you ever had an abnormal Pap Smear? YES NO If yes, when and where were you treated? _____
   What was the diagnosis? _____
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. Have you ever used an IUD (intrauterine device) for contraception? YES NO If yes, please indicate when: _____
   Did you have any problem with the IUD? YES NO Please describe: ___
5. Do you have a history of infertility? YES NO If yes, please describe: __
6. Please list any other concerns you have related to your past health history:
7. When was the first day of your last menstrual period? _____

FAMILY HISTORY & GENETIC HISTORY

1. Heave 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 child 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 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
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father is 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 circle 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? _____
   Hypertension YES NO — If yes, how is that person related to you? _____
   Cancer 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. Do you or the baby's father have a history of twins/ multiple babies? Yes No
9. Will you be 35 or older at the time the baby is born? YES NO
10. Will the father be 50 or older? YES NO

Advanced Directives (end of life issues)

Do you currently have a living will or advanced Directives:____yes ____no
Please consult with your health provider with any of life issues, advanced care directives that you desire to put in place or receive information regarding these issues.
Yes, I would like to receive information __ No, I don't not require any information ___

How did you hear about us? Did someone refer you?
If so… We would like to thank them!
Doctor: _____ Family/Friends: _____
Web: Google Yahoo MSN : search keywords _____
Insurance Co: _____ Other: _____

Are you pregnant with multiple babies _____ If so, how many_____
Baby's Name _____
Estimated Due Date _____
Number of previous pregnancies _____
Number of Children _____

Have you experienced any changes recently: (CIRCLE all that apply)

Loss of work	Promotion	Loss of income	Increase in Income
Death in Family	Addition to Family	Injury to self or family member	ADHD
Sore Breast	Bleeding	Nausea	Varicose Veins
Sleep Disturbance	Anxiety	Depression	Sudden Swelling

Current Nutrition/Diet _____
Current Complications _____
Hospital Preference in case of Emergency: _____ _____
Name of Hospital Phone Number
What medications are you currently taking: _____
_____
Do you consume alcohol? _____ How often? _____
Do you take recreational drugs? _____ How often? _____
Do you have medical problems, recent injuries or surgeries: _____

Please CIRCLE any of the following that apply:

Back Pain/Type?_____	Stroke	Diabetes	Carpal Tunnel
Cancer/Type? _____	Arthritis	Anemia	Low Blood Pressure
Allergies/Type? _____	Heart Disease	Sciatic Nerve Pain	
Surgery/Where? _____			
Other _____			

When was your last Massage _____ How often do you get Massaged _____
Would you be interested in an Aromatherapy Massage? YES NO
If you answered yes, do you have any allergies? _____

Support Network:
Partner _____
Name Occupation Phone Number
Obstetrics & Gynecology Surgeon _____
Name Address Phone Number
Doula _____
Name Address Phone Number

Authorization: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for all service rendered on my dependents or my behalf. I consent to/and authorize treatment for the above named patient. I authorize the release of any information requested by health professionals participating in my care.
Name: _____
Signature: _____ Date: _____