

OBSTETRIC MEDICAL HISTORY

Patient Name: _____

Date Form Completed: _____

* If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. Yes No Are you allergic to any medications?

If yes, please list: _____

2. Please mark any condition that you have or have had in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis or lupus | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> von Willebrand's disease or other bleeding disorders | | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Blood clotting disorder (eg, phlebitis) | | <input type="checkbox"/> Recurrent urinary tract infections |

Describe, if needed: _____

3. Please indicate any surgery that you have had: _____

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

5. Yes No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. Yes No Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)?

If yes, please describe: _____

EXPOSURES AFFECTING HEALTH

1. Yes No Do you smoke cigarettes?
If yes, how many packs per day? _____

2. Yes No Do you drink alcoholic beverages?
If yes, how often? _____
What type of drinks? _____

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. Yes No Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)?

6. Yes No Are you ever exposed to chemicals or radiation (eg, X-rays)?
If yes, please describe: _____

7. Yes No Are you on a restricted diet?
If yes, please describe: _____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____
 Yes No Have you ever had an abnormal Pap test?
If yes, when and how were you treated? _____

What was the diagnosis? _____

2. Yes No Have you ever had gonorrhea , chlamydia , or pelvic inflammatory disease ?
If yes, when, how, and where were you treated? _____

3. Yes No Have you ever had herpes?
If yes, how often do you have outbreaks? _____
 Yes No Have you ever had syphilis?
If yes, how, when, and where were you treated? _____

4. Yes No Have you ever used an IUD (intrauterine device) for contraception?
If yes, please indicate when: _____
 Yes No Did you have any problem with the IUD?
If yes, please describe: _____

5. Yes No Have you been treated for infertility?
If yes, please describe when and treatment received: _____

6. Yes No Do you have any other concerns related to your past health history?
If yes, please list: _____

DATE _____
 NAME _____
 LAST FIRST MIDDLE
 ID # _____ HOSPITAL OF DELIVERY _____
 NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS
MONTH DAY YEAR			EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
OCCUPATION	HUSBAND/DOMESTIC PARTNER PHONE			INSURANCE CARRIER/MEDICAID #
LANGUAGE	FATHER OF BABY PHONE			POLICY #
TOTAL PREG		FULL TERM	PREMATURE	AB, INDUCED
				AB, SPONTANEOUS
				ECTOPICS
				MULTIPLE BIRTHS
				LIVING

MENSTRUAL HISTORY

LMP DEFINITE APPROXIMATE (MONTH KNOWN) UNKNOWN FINAL _____
 MENSES MONTHLY YES NO FREQUENCY: 0 _____ DAYS MENARCHE _____ (AGE ONSET)
 PRIOR MENSES _____ DATE ON BCP AT CONCEPT YES NO HCG + _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

MEDICAL HISTORY

	<input type="checkbox"/> Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT	<input type="checkbox"/> Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES				17. 0 (Rh) SENSITIZED
2. HYPERTENSION				18. PULMONARY (TB, ASTHMA)
3. HEART DISEASE				19. SEASONAL ALLERGIES
4. AUTOIMMUNE DISORDER				20. DRUG/LATEX ALLERGIES/ REACTIONS
5. KIDNEY DISEASE/UTI				21. BREAST
6. NEUROLOGIC/EPILEPSY				22. GYN SURGERY
7. PSYCHIATRIC				23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)
8. DEPRESSION/POSTPARTUM DEPRESSION				24. ANESTHETIC COMPLICATIONS
9. HEPATITIS/LIVER DISEASE				25. HISTORY OF ABNORMAL PAP
10. VARICOSITIES/PHLEBITIS				26. UTERINE ANOMALY/DES
11. THYROID DYSFUNCTION				27. INFERTILITY
12. TRAUMA/VIOLENCE				28. RELEVANT FAMILY HISTORY
13. HISTORY OF BLOOD TRANSFUS.				29. OTHER
	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE	
14. TOBACCO				
15. ALCOHOL				
16. ILLICIT/RECREATIONAL DRUGS				

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM 1)

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING					
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:					
	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS AS OF ESTIMATED DATE OF DELIVERY			12. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND); MCV <80			13. MENTAL RETARDATION/AUTISM		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
6. TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)			16. PATIENT OR BABY'S FATHER HAD A CHILDO WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN DISEASE			17. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. MUSCULAR DYSTROPHY			19. ANY OTHER		
11. CYSTIC FIBROSIS					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. OTHER (See Comments)		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD					

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

* INITIAL PHYSICAL EXAMINATION * <i>Dr. Filskin</i>					
DATE	HEIGHT	BP			
1. HEENT	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	12. VULVA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> CONDYLOMA	<input type="checkbox"/> LESIONS
2. FUNGI	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	13. VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> DISCHARGE
3. TEETH	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	14. CERVIX	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> LESIONS
4. THYROID	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	15. UTERUS SIZE	_____ WEEKS		<input type="checkbox"/> FIBROIDS
5. BREASTS	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	16. ADNEXA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> MASS	
6. LUNGS	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	17. RECTUM	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	
7. HEART	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	18. DIAGONAL CONJUGATE	<input type="checkbox"/> REACHED	<input type="checkbox"/> NO	_____ CM
8. ABDOMEN	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	19. SPINES	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> PROMINENT	<input type="checkbox"/> BLUNT
9. EXTREMITIES	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	20. SACRUM	<input type="checkbox"/> CONCAVE	<input type="checkbox"/> STRAIGHT	<input type="checkbox"/> ANTERIOR
10. SKIN	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	21. SUBPUBIC ARCH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> WIDE	<input type="checkbox"/> NARROW
11. LYMPH NODES	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	22. GYNECOID PELVIC TYPE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

COMMENTS (Number and explain abnormal) _____

EXAM BY _____

ACOG ANTEPARTUM RECORD (FORM B)

FAMILY HISTORY & GENETIC SCREENING

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

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

3. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

How is this child/person related to you? _____

4. Yes No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)?
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? _____

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

Yes No Eastern Europe Jewish ancestry
If yes, have you had Tay-Sachs screening tests? Yes No
If yes, have you had a Canavan screening test? Yes No
Date _____ Result _____

Yes No African American
If yes, have you had sickle cell screening? Yes No
Date _____ Result _____

Yes No European Ancestry
If yes, have you had cystic fibrosis screening? Yes No

Yes No Mediterranean Ancestry or Southeast Asian Ancestry
If yes, have you had screening for inherited forms of anemia such as thalassemia? Yes No

6. Please list any other concerns you have about birth defects or inherited disorders:

7. Yes No Will you be 35 years or older at the time the baby is born?

8. Yes No Will the father be 50 years or older?

PSYCHOSOCIAL SCREENING*

1. Yes No Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?

2. Yes No Do you feel unsafe where you live?

3. Yes No In the past 2 months, have you used any form of tobacco?

4. Yes No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?

5. Yes No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?

6. Yes No Has anyone forced you to perform any sexual act that you did not want to do?

7. On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High

8. How many times have you moved in the past 12 months? _____

9. If you could change the timing of this pregnancy, would you want it
 Earlier
 Later
 Not at all
 No change

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

Patient Signature

Print Name

Date