OBSTETRIC MEDICAL HISTORY

		PERSONAL HEALTH I	cuss them with your doctor or nurse.	
		PERSONAL NEACHT		
1. ☐ Yes ☐ No	Are you allergic to any medica	ations?	•	
	If yes, please list:			
 				
2.	Please mark any condition that	at you have or have had in the	past:	
,	☐ Cancer	☐ HIV/AIDS	□ Diabetes	
	☐ Epilepsy	☐ Thyroid disorder	☐ Eating disorder	
	☐ Heart disease	☐ Headaches	Depression	
-	High blood pressure	☐ Arthritis or lupus	C Assima	
•	☐ Kidney disease	☐ Frequent Infections	☐ Anemia ☐ Herpes	
	 Hepalitis 	Bowel disease	Sexually transmitted diseases	
	O von Willebrand's disease of		☐ Recurrent urinary tract infections	
	☐ Blood clotting disorder (eg.	, priedius)		
	Describe, if needed:			
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3.	Please indicate any surgery the	hat you have had:		
		<u></u>		
Δ	Please describe any health p	roblerns or symptoms that you	are having at this time:	
٦.				
		have a history of problems wi	th anesthesia?	
		nave a hisiory of procients ***		
5. 🗆 Yes 🗀 No	Do you or any family member	Tigro a motory		
5. 🗆 Yes 🗆 No	Do you or any family member If yes, please describe:	The Control of the Co		
5. 🛘 Yes 🗍 No	Do you or any family member If yes, please describe:			
5. 🛘 Yes 🗆 No	Do you or any family member If yes, please describe:			
	If yes, please describe:			
	If yes, please describe:	jections to any form of medica		

1. Yes No No No you shoke cigarettes? If yes, how many packs per day? No No Yes No No you driek accinote beverage? No Yes No No No Yes Yes No No No Yes Yes No No No Yes Yes Yes No No No Yes Yes Yes Yes Yes No No No Yes		EXPOSURES AFFECTING HEALTH
Il yes, how many packs per day?		
2. O Yes O No Coyou drank alcoholic beverages? If yes, how often? What Upe of drinler? What Upe of drinler? What Upe of drinler? Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: Please list any illicit or recreational drugs used since your last period (eg. cocaine, marijuans): 5. O Yes O No Do you have any reason to believe you may have been exposed to ATDS (eg. a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a galy or biseval male, exposure to an intravenous drug user)? 7. O Yes O No Are you ever exposed to chemicals or radiation (eg. X-rayya)? 1. O Yes O No Have you or a estricted driet? 1. O Yes O No Have you user had an abnormal Pap Ites? 1. O Yes O No Have you ever had an abnormal Pap Ites? 1. O Yes O No Have you ever had gonorthea O, chlamydia O, or pelvic inflammatory disease O ? 1. O Yes O No Have you ever had depondrhea O, chlamydia O, or pelvic inflammatory disease O ? 1. O Yes O No Have you ever had hepse? 2. O Yes O No Have you ever had hepse? 3. O Yes O No Have you ever had hepse? 4. O Yes O No Have you ever used an IUD (intraviterine device) for contraception? 1. O Yes O No O Have you ever used an IUD (intraviterine device) for contraception? 1. O Yes O No O N	1, 🖸 Yes 🖸 No	Do you smoke cigarettes:
What type of drinks? Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitarrans, other supplements, and any herbal medicines:	2. 🗆 Yes 🛚 No	Do you drink alcoholic beverages?
Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines:		If yes, how often?
supplements, and any herbal medicines:		What type of drinks?
4. Ploase list any lifect or recreational drugs used since your last period (eg., cocaine, mar/juana): 5. Yes No No Do you have any reason to believe you may have been exposed to AIDS (eg. a history of blood transfusion, intravenous drug user)? 6. Yes No Are you ever exposed to chemicals or radiation (eg. X-rays)? 17 Yes No Are you on a restricted diet? 18 Yes No Have you ever had an abnormal Pap test? 19 Yes No Have you ever had an abnormal Pap test? 19 Yes No Have you ever had gonorrhea C. Nhamydia D. or pelvic inflammatory disease P. Yes Yes, how often do you have outbreaks? 19 Yes No Have you ever had herpes? 10 Yes No Have you ever had herpes? 11 Yes, how often do you have outbreaks? 12 Yes No Have you ever had herpes? 13 Yes No Have you ever had herpes? 14 Yes No Have you ever had herpes? 15 Yes, how often do you have outbreaks? 16 Yes No Have you ever had philips? 17 Yes, please didicate when: 18 Yes No Have you ever had philips? 19 Yes, please describe: 19 Yes No Have you ever had philips? 19 Yes, please describe: 20 Yes No Have you ever had herpes? 19 Yes, please describe: 20 Yes No Have you ever had her were you treated? 31 Yes No Have you ever had philips? 19 Yes, please describe: 32 Yes No No Have you ever had here were you treated? 33 Yes No No Have you ever had here were you treated? 44 Yes No No Have you ever had here were you treated? 45 Yes No No Have you ever had here were you treated? 46 Yes No No Have you ever had here were you treated? 47 Yes Yes No No Have you ever had here were you treated? 48 Yes No No Have you ever had here were you treated? 49 Yes Yes No No Have you ever had here were you treated? 40 Yes Yes No No No Yes Yes	3.	Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, motivations, con-
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5. Yes No No Oo 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 No Are you ever exposed to chemicals or radiation (eg. X-rays)? 11 Yes No No Are you on a restricted diet? 12 Yes No No Have you ever had an abnormal Pap test? 13 Yes No Have you ever had gonorihea C. chlamydia O. or pelvic inflammatory disease ? 14 Yes No Have you ever had show were you treated? 15 Yes No Have you ever had herpes? 16 Yes No Have you ever had herpes? 17 Yes No Have you ever had herpes? 18 Yes, how often do you have outbreaks? 19 Yes No Have you ever had sphilis? 19 Yes No Have you ever had philis? 10 Yes No Have you ever had herpes? 11 Yes, how when, and where were you treated? 12 Yes No Have you ever had herpes? 13 Yes No Have you ever had herpes? 14 Yes No Have you ever had herpes? 15 Yes, please describe: 16 No No No No No No No N		
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6.	s s No. C No.	Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous
If yes, please describe:	5. Li tes Li No	drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to an initial or sexual exposure to a gay or bisexual male, exposure to a gay
If yes, please describe:	e CI Vae CI No	Are you ever exposed to chemicals or radiation (eg, X-rays)?
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GYNECOLOGIC HEALTH HISTORY 1.	7. 🖸 Yes 🗆 No	
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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?		TARLACIO NEALTH HISTORY
Yes No		
If yes, when and how were you treated? What was the diagnosis? No Have you ever had gonorrhea □, chlamydia □, or pelvic inflammatory disease □? If yes, when, how, and where were you treated? 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? Have you ever used an IUD (infrauterine device) for contraception? If yes, please indicate when: Yes □ No Did you have any problem with the IUD? If yes, please describe: No Have you been treated for infertility? If yes, please describe when and treatment received: No Do you have any other concerns related to your past health history?	1.	When was your last Pap test?
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If yes, please describe: 5. ① Yes ② No Have you been treated for infertility? If yes, please describe when and treatment received: On Yes ② No On you have any other concerns related to your past health history?	G Yac □ No	Did you have any problem with the IUD?
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If yes, please list:	6. 🗆 Yes 🗆 No	Do you have any other concerns related to your past nearth history:
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8 DEPE	ESSION/PO	STPARTUM		l					**************************************		-	- .	
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	ACCO.							28. RE	LEVANT FAMIL	Y HISTORY			
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₹	•	INCLUDES PAT		S _. FATHER. NO	OR ANYONE IN EITHER FAMILY WITH:	YES	, N
	IN LOS AS OF CETHATS	O DATE OF DELIVERY	YES	1	12. HUNTINGTON'S CHOREA		
1. PATIENT'S AGE 2 35 Y					13. MENTAL RETARDATION/AUTISM	T	
2. THALASSEMIA (ITALI ASIAN BACKGROUN	AN, GREEK, MEDITERH D): MCV <80			L	IF YES, WAS PERSON TESTED FOR FRAGILE X?	1	
3. NEURAL TUBE DEFE	CT	A MICHOCOLIAN VO			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
	LE, SPINA BIFIDA, OR	ANENCEPHACI		 	15. MATERNAL METABOLIC DISORDER (EG. TYPE 1 DIABETES, PKU)	<u> </u>	
4. CONGENITAL HEART	DEFECT				16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS	<u> </u>	ĺ
5. DOWN SYNOROME		, , , , , , , , , , , , , , , , , , ,		 	NOT LISTED ABOVE	<u> </u>	ļ
6. TAY-SACHS (EG, JEV	VISH, CAJUN. FRENCH	CANAUIAN)	+	ļ 	17. RECURRENT PREGNANCY LOSS, OA A STILLBIRTH	<u> </u>	<u> </u>
7. CANAVAN DISEASE			ļ	 	18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE		
8. SICKLE CELL DISEAS			 	 	LAST MENSTRUAL PERIOD	 	
9. HEMOPHILIA OR OTH		15		<u> </u>	IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. MUSCULAR DYSTRO	PHY		- 	<u> </u>	19. ANY OTHER	1	\vdash
1. CYSTIC FIBROSIS	==		<u>. </u>	<u> </u>	S. ACTOTILA		
OMMENTS/COUN						YES	N
OMMENTS/COUN			YES	NO		YES	N
OMMENTS/COUN	DRY	D TO TB	YES	NO	4. HISTORY OF STO, GONORRHEA, CHLAMYOIA, HPV, SYPHILIS	YES	N
OMMENTS/COUNTINFECTION HISTOR	DRY E WITH TB OR EXPOSE		YES	NO		YES	N
OMMENTS/COUN INFECTION HISTO 1. LIVE WITH SOMEONE 2. PATIENT OR PARTINE	DRY E WITH TB OR EXPOSE R HAS HISTORY OF GE	NITAL HERPES	YES	ио	4. HISTORY OF STD, GONORFIHEA, CHLAMYDIA, HPV, SYPHILIS 5. OTHER (See Comments)	YES	N
OMMENTS/COUNTINFECTION HISTOR	DRY E WITH TB OR EXPOSE R HAS HISTORY OF GE	NITAL HERPES	YES	NO		YES	N
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	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)?
4. [] 165 [] 140	If yes, have either of you had genetic counseling?
	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?
	If yes, have you had a Canavan screening test?
	Date
∏ Yes ☐ No	African American
	If yes, have you had sickle cell screening?
	Date Result
	European Ancestry
U Yes U IVO	If yes, have you had cystic fibrosis screening?
☐ Yes ☐ No	Mediterranean Ancestry or Southeast Asian Ancestry If yes, have you had screening for inherited forms of anemia such as thalassemia?
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*
ı. □ Yes □ No	Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No	Do you feet unsafe where you live?
	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 rale 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
J.	© Earlier
	□ Later
	O Not at all
	☐ No change
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