Obstetrical
Medical History

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PATIENT NAME: _____ DATE FORM COMPLETED: _____

IF YOU ARE UNCOMFORTABLE ANSWERING ANY QUESTIONS, LEAVE THEM BLANK; YOU CAN DISCUSS THEM WITH THE DOCTOR OR NURSE.

PERSONAL HEALTH HISTORY

1. ◯ YES ◯ NO ARE YOU ALLERGIC TO MY MEDICATIONS?

IF YES, PLEASE LIST: _____

ANY OTHER ALLERGIES? _____

2. PLEASE MARK ANY CONDITION THAT YOU HAVE HAD IN THE PAST:

- ☐ EPILEPSY
- ☐ HEADACHES
- ☐ THYROID DISORDER
- ☐ BREAST DISEASE
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER
- ☐ ANEMIA
- ☐ VON WILLEBRAND DISEASE OR OTHER BLEEDING DISORDERS
- ☐ BLOODCLOTTING DISORDER (E.G. PHLEBITIS/THROMBOPHILIA
- ☐ BLOOD TRANSFUSION
- ☐ GASTROINTESTINAL ILLNESS
- ☐ HEPATITIS
- ☐ KIDNEY DISEASE
- ☐ RECURRENT URINARY TRACT INFECTIONS
- ☐ GESTATIONAL DIABETES
- ☐ DIABETES (TYPE 1 OR 2)
- ☐ ARTHRITIS OR LUPUS
- ☐ SKIN DISORDERS
- ☐ PRIOR PRETERM BIRTH
- ☐ GROUP B STREPTOCOCCUS IN PRIOR PREGNANCY
- ☐ HERPES
- ☐ SEXUALLY TRANSMITTED INFECTIONS
- ☐ HIV/AIDS
- ☐ FREQUENT INFECTIONS
- ☐ PSYCHIATRIC ILLNESS
- ☐ DEPRESSION/POSTPARTUM DEPRESSION
- ☐ EATING DISORDER
- ☐ OTHER

DESCRIBE, IF NEEDED: _____

3. PLEASE INDICATE ANY SURGERY OR HOSPITALIZATION THAT YOU HAVE HAD AND THE DATE:

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 OR BLOOD TRANSFUSION)? _____

EXPOSURES AFFECTIG HEALTH

1. ◯ YES ◯ NO DO YOU SMOKE CIGARETTES?

IF FORMER SMOKER, WHEN DID YOU QUIT? _____ IF YES, HOW MANY PACKS PER DAY? _____

2. ◯ YES ◯ NO DO YOU DRINK ALCOHOL BEVERAGES NOW OR DID YOU BEFORE YOU BECAME PREGNANT?

IF YES, PLEASE INDICATE NUMBER OF DRINKS PER WEEK: _____

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. ◯ YES ◯ NO HAVE YOU USED ANY STREET DRUGS SINCE YOUR LAST MENSTRUAL PERIOD (EG, COCAINE, MARIJUANA)?

IF YES, PLEASE INDICATE NUMBER OF USES PER WEEK: _____

WHAT TYPE OF DRUGS? _____

5. ◯ YES ◯ NO DO YOU HAVE ANY REASON TO BELIEVE YOU MAY HAVE BEEN EXPOSED TO HIV/AIDS (EG, A HISTORY OF BLOOD TRANSFUSION, INTRAVENOUS DRUG USE, MULTIPLE SEXUAL PARTNERS, SEXUAL EXPOSURE TO A GAY OR BISEXUAL MALE, OR SEXUAL EXPOSRE TO AN INTRAVENOUS DRUG USER)?

6. ◯ YES ◯ NO HAVE YOU BEEN EXPOSED TO CHEMICALS (EG PESTICIDES, LEAD, HAZARDOUS MATERIAL/ AGENTS) OR RADIATION (EG X-RAYS) SINCE YOU BECAME PREGNANT?

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 RECEIVED THE HPV VACCINE?

◯ YES ◯ NO HAVE YOU EVER HAD AN ABNORMAL PAP TEST?

IF YES, WHEN AND HOW WERE YOU TREATED? _____

WHAT WAS THE DIAGNOSIS? _____

◯ YES ◯ NO HAVE YOU EVER HAD HPV?

2. HAVE YOU EVER HAD ◯ GONORRHEA ◯ CHLAMYDIA ◯ PELVIC INFLAMMATORY DISEASE

IF YES, WHEN, AND HOW 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, WHEN AND HOW 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 PROBLEMS WITH YOUR 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 CONCERNED RELATED TO YOUR PAST HEALTH HISTORY?

IF YES PLEASE LIST: _____

FAMILY HISTORY & GENETIC SCREENING

1. WHAT IS YOUR ETHNICITY? _____ WHAT IS THE ETHNICITY OF THE BABY'S FATHER? _____

2. ◯ YES ◯ NO HAVE YOU OR HAS THE BABY'S FATHER HAD A CHILD WITH A BIRTH DEFECT?

IF YES, PLEASE DESCRIBE: _____

3. ◯ YES ◯ NO DID EITHER YOU OR THE BABY'S FATHER HAVE A BIRTH DEFECT?

IF YES, PLEASE DESCRIBE: _____

4. PLEASE DESCRIBE ANY SPECIAL NEEDS THAT HAVE OCCURED IN CHILDREN OF YOUR FAMILY OR THE BABY'S FATHER'S FAMILY (EG,MENTAL RETARDATION, BIRTH DEFECTS, EARLY INFANT DEATH, DEFORMITIES, OR INHERITED DISEASES SUCH AS HEMOPHILIA, MUSCULAR DYSTROPHY, OR CYSTIC FIBROSIS): _____

_____

HOW OLD IS THIS CHILD/PERSON RELATED TO YOU?

5. ◯ YES ◯ NO DO YOU OR DOES THE BABY'S FATHER HAVE A HISTORY OF PREGNANCY LOSSES (MISCARRIAGES OR STILLBIRTHS)?

◯ YES ◯ NO IF YES, HAVE EITHER OF YOU HAD GENETIC COUNSELING?

◯ YES ◯ NO IF YES, HAVE EITHER OF YOU HAD CHROMOSOMAL TESTING?

WHERE AND WHAT WERE THE RESULTS? _____

6. ◯ YES ◯ NO SOME GENETIC PROBLEMS OCCUR MORE IN COUPLES WITH CERTAIN RACIAL OR ANCESTRAL BACKGROUNDS. PLEASE CHECK IF YOU OR THE BABY'S FATHER IS OF ONE OF THESE BACKGROUNDS: EASTERN EUORPEAN JEWISH (ASHKENAZI) ANCESTRY?

◯ YES ◯ NO IF YES, HAVE YOU HAD TAY-SACHS SCREENING TEST?

◯ YES ◯ NO IF YES, HAVE YOU HAD A CANAVAN SCREENING TEST?

◯ YES ◯ NO IF YES, HAVE YOU HAD CYSTIC FIBROSIS SCREENING?

◯ YES ◯ NO IF YES, HAVE YOU HAD FAMILIAL DYSAUTONOMIA SCREENING?

DATE: _____ RESULT: _____

◯ YES ◯ NO AFRICAN AMERICAN

◯ YES ◯ NO IF YES, HAVE YOU HAD SICKLE CELL SCREENING?

DATE: _____ RESULT: _____

◯ YES ◯ NO MEDITERRANEAN ANCESTRY OR SOUTHEAST ASIAN ANCESTRY?

◯ YES ◯ NO IF YES, HAVE YOU HAD SCREENING FOR INHERITED FORMS OF ANEMIA SUCH AS THALASSEMIA?

◯ YES ◯ NO FRENCH CANADIAN OR CAJUN ANCESTRY?

◯ YES ◯ NO IF YES, HAVE YOU HAD TAY-SACHS SCREENING TEST?

7. ◯ YES ◯ NO HAVE YOU HAD CYSTIC FIBROSIS SCREENING?

8. PLEASE LIST ANY OTHER CONCERNS YOU HAVE ABOUT BIRTH DEFECTS OR INHERITED DISORDERS:

_____

_____

_____

_____

9. ◯ YES ◯ NO DO YOU WANT A DOWNS SYNDROME RISK ASSESSMENT?

10. ◯ YES ◯ NO IS THE FATHER 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 APPOINTMENT?
2. ◯ YES ◯ NO	DO YOU FEEL UNSAFE WHERE YOU LIVE?
3. ◯ YES ◯ NO	ARE YOU EXPOSED TO SECOND HAND SMOKE?
◯ 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	

*Modified and reprinted with permission from Florida's healthy start prenatal risk screening instrument. Florida department of health DH3134 Sept 1997

PATIENT SIGNATURE:

_____

NAME PRINTED OR TYPED:

_____

DATE:

_____

NOTES

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