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|-------|------------|
| MRN: | 4289193 |
| NAME: | Test, Amy |
| DOB: | 09/17/1981 |
| PCP: | |
| DATE: | 7/6/2022 |

OBSTETRIC MEDICAL HISTORY FORM

Patient Name: Test, Amy Birth Date: 09/17/1981 Age: _____
 MRN: 4289193 Today's Date: 7/6/2022 Date of Last Menstrual Period? _____

How many times have you been pregnant? _____ How many miscarriages did you have? _____
 How many children have you delivered? _____ How many abortions did you have? _____
 How many were born full term (37 weeks or greater)? _____ How many children are currently living? _____
 How many were premature (less than 37 weeks)? _____ How many sets of twins? _____

Have you or your partner traveled to a Zika affected Region? Yes No I don't know

PAST PREGNANCIES (LAST SIX)

| Pregnancies | Delivery Date Month/Year | Weeks at delivery | Length of labor | Birth Weight | Sex M/F | Vaginal Delivery or C/section | Epidural or General Anesthetic | Hospital of Delivery | Pre-term Labor Yes/No | Complications Yes/No |
|-------------|-----------------------------|----------------------|--------------------|-----------------|------------|-------------------------------------|--------------------------------------|-------------------------|-----------------------------|-------------------------|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

When was your last Pap Smear? _____ / _____ / _____ NEVER _____

My last Pap Smear was _____ normal or _____ abnormal or _____ I don't know

Have you ever had any Abnormal Pap Smears? Yes No _____ / _____ / _____ NEVER _____

When was your last Mammogram? (Ok to give approximate date) _____ / _____ / _____ NEVER _____

My last Mammogram was _____ normal or _____ abnormal or _____ I don't know _____ / _____ / _____ NEVER _____

Check the follow infections or Sexually Transmitted Disease (STD or Venereal Disease) you have had in the past.

None ever Hepatitis (B or C) Bacterial Vaginosis (Gardnerella) Others: _____

Chlamydia Syphilis Human Papilloma Virus (HPV)

Gonorrhea (GC, Clap) Trichomoniasis Herpes (Genital or Oral)

How many Sexual Partners in your lifetime? 0 1-4 5 or greater

Were you using birth control? None or _____ (What type)

Marital Status: Single Married Living with Partner Widowed Divorced/ Separated

Occupation: _____ Homemaker Student Retired

What Medications are you currently taking?

| Medication Name: | Dosage | Medication Name: | Dosage |
|------------------|--------|------------------|--------|
| | | | |
| | | | |

List of medications you are allergic to: _____ No known drug allergies:

| Medication Name: | Reaction | Medication Name: | Reaction |
|------------------|----------|------------------|----------|
| | | | |
| | | | |

OBSTETRIC MEDICAL HISTORY FORM

MEDICAL PROBLEMS

| | Yes/No | | | Yes/No |
|---|--------|---|--|--------|
| Diabetes | | Pulmonary/Asthma/T.B. | | |
| Hypertension | | Seasonal allergies | | |
| Heart Disease | | Drug/Latex allergic reaction | | |
| Autoimmune Disease | | Breast cancer/ OR other issues | | |
| Kidney disease/urinary tract infections | | Female Surgery : Myomectomy, Fibroid removal , Ovary removed, Ectopic Pregnancy , LEEP, Cold knife cone, any other female surgery | | |
| Neurologic problems /epilepsy | | Operations/Hospitalizations | | |
| Psychiatric problems | | | | |
| Depression | | Anesthetic complications | | |
| Postpartum depression | | | | |
| Hepatitis/Liver disease | | History of abnormal Pap Smear | | |
| Varicosities/Blood clots | | Uterine abnormalities | | |
| Low thyroid/ High thyroid | | Infertility | | |
| History of Blood transfusions | | Art treatment | | |
| Blood disorders | | Pregnancy complications | | |
| Stomach problems | | Cancer | | |
| Skin problems | | Relevant family history | | |
| D(RH) sensitized | | | | |
| | | Uterine abnormalities | | |
| | | Other | | |

| | | | | |
|--|---|---|--|--|
| Tobacco use:: Yes / No Amount per pregnancy _____ Amount now _____ | Alcohol use: : Yes / No Amount per pregnancy _____ Amount now _____ | Illicit/Recreational drugs Yes / No Pre-pregnancy _____ Amount now _____ | Sexual Abuse? Yes / No Are you safe now? Yes / No | Domestic Abuse? Yes / No Are you safe now? Yes / No |
|--|---|---|--|--|

GENETIC SCREENING

PATIENT HISTORY, FATHER OF THE BABY, OR ANYONE IN EITHER FAMILY

| | Yes/No |
|--|--------|
| Age ____ > 35 Yrs at delivery date | |
| Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV < 80 | |
| Neutral tube defect (Meningomyelocele, Spina Bifida, or Anencephaly) | |
| Congenital Heart Defect Heart Defect | |
| Down Syndrome | |
| Tay Sachs (EG, Ashkenazi Jewish, Cajun, French Canadian) | |
| Canavan Disease (Ashkenazi Jewish) | |
| Sickle Cell Disease or Trait (African) | |
| Hemophilia or other blood disorders | |
| Muscular Dystrophy | |
| Cystic Fibrosis | |
| Huntington's Chorea | |
| Mental Retardation/Autism IF yes was person tested for Fragile X? | |
| Other Inherited genetic or chromosomal disorder | |
| Maternal Metabolic Disorder (Type 1 diabetes, PKU) | |
| Patient or baby's father had a child with birth defects not listed above | |
| Recurrent pregnancy loss or stillbirth | |
| Live with someone with TB or exposed to TB | |
| Patient or partner has history of genital herpes | |
| Rash or viral illness since last menstrual period | |
| Prior Beta Strep infection in child | |
| Gonorrhea | |

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD

Patient Signature: _____ Medical Provider _____