http://lasformswb01/FormsOnDemand/CrystalImageHandler.aspx?dynamicimage=cr_tmp_image_da5b9a51-9c88-41d4-bfc4-ccacd5f78c6a.png

**OBSTERIC MEDICAL HISTORY FORM Age: \_\_\_\_\_ MEDICAL RECORD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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**  **Y/N** | **Complications**  **Y/N** |
| **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 MEDICATIONS YOU ARE ALLERGIC TO: \_\_\_ NO KNOWN DRUG ALLERGIES**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION NAME:** | **REACTION** | **MEDICATION NAME:** | **REACTION** |
|  |  |  |  |
|  |  |  |  |

**MEDICAL PROBLEMS**

**YES/NO YES/NO**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DIABETES** |  | **PULMONARY /ASTHMA/T.B.** |  |  |
| **HYPERTENSION** |  | **SEASONAL ALLERGIES** |  |
| **HEART DISEASE** |  | **DRUG/LATEX ALLERGIC REACTION** |  |
| **AUTOIMMUNE DISORDER** |  | **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**  **POSTPARTUM DEPRESSION** |  | **ANESTHETIC COMPLICATIONS** |  |
| **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 PRE-PREGNANCY**  **\_\_\_\_**  **AMOUNT NOW\_\_\_\_\_\_\_** | **ALCOHOL USE : YES/NO**  **AMOUNT PRE-PREGNANCY**  **\_\_\_\_**  **AMOUNTNOWN\_\_\_\_\_\_** | **ILLICIT/RECREATIONAL DRUGS YES/NO**  **PRE-PREGNANCY\_\_\_\_\_**  **AMOUNT NOW\_\_\_\_\_\_** | **Sexual Abuse? \_\_\_Y/N**  **Are you safe now? \_\_\_Y/N** | **Domestic Abuse? \_\_\_Y/N**  **Are you safe now? \_\_\_Y/N** |

**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 VACKGROUND): MCV < 80** |  |
| **NEURAL 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** |  |
| **METAL 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** |  |
| **PATIEN OR PARTNER HAS HISTORY OF GENITAL HERPES** |  |
| **RASH OR VIRAL ILLNESS SINCE LAST MENSTRAL PERIOD** |  |
| **PRIOR BETA STREP INFECTION IN CHILD** |  |
| **GONORRHEA** |  |

**THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**