

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**