OB Health History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Name_____ Age: ____ DOB: ___/___/___ Height_____ Date: ___/___/____
List your Primary Care Physician: _____ Last menstrual period: ____/____/_____
Reason for your visit today: _____

List all Allergies & Adverse Reactions

_____
_____
_____

List all Medications/Supplements/Herbal and Dosage

_____
_____
_____
_____
_____
_____
_____

Vaccine Immunization (Flu, Tdap, etc…) & Date received

_____
_____

Past Medical History
Check all diseases and conditions that apply

- ☐ Abuse / Domestic Violence
- ☐ Acne
- ☐ ADHD
- ☐ Allergies (environmental/food)
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bi-Polar
- ☐ Breast Cancer
- ☐ Breast Disease
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Colon Polyp
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Dermatologic Disorder
- ☐ Diabetes Mellitus
- ☐ Diverticulitis
- ☐ Ear or Hearing Disorder
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Endocrine Disorder
- ☐ Fibromyalgia
- ☐ Gastroesophageal Reflux Disease
- ☐ Gastrointestinal Disease
- ☐ Genetic / Hereditary Disorder
- ☐ Genitourinary Disease
- ☐ HIV or AIDS
- ☐ Headaches
- ☐ Hematologic Disease
- ☐ Hepatic / Liver Disease
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ IBS
- ☐ Immunologic Disorder
- ☐ Kidney Stones
- ☐ Menopause
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Musculoskeletal Disease
- ☐ Neurologic Disorder
- ☐ Obesity
- ☐ Osteoporosis/Osteopenia
- ☐ Ovarian Cancer
- ☐ Psychiatric Illness
- ☐ Pulmonary / Lung Disease
- ☐ Renal / Kidney Disease
- ☐ Seizures / Epilepsy
- ☐ Sleep Apnea
- ☐ Substance Abuse/Dependence
- ☐ Thrombophilia
- ☐ Thyroid Disease
- ☐ (GERD)
- ☐ Urologic Disorder
- ☐ Vision / Eye Disorder
- ☐ Vitamin D Deficiency
- ☐ Other_____

Past Surgical History
Check all diseases and conditions that apply

- ☐ Appendectomy
- ☐ Back / Spine Surgery
- ☐ Breast Biopsy
- ☐ Breast Surgery
- ☐ Breast surgery – augmentation
- ☐ Breast Surgery – Lumpectomy
- ☐ Caesarean Section
- ☐ Cardiac – Angioplasty
- ☐ Cardiac – Catheterization
- ☐ Cardiac - Coronary Artery Bypass
- ☐ Cardiac - Coronary Artery Stent
- ☐ Cardiac Surgery
- ☐ Cholecystectomy (gallbladder)
- ☐ Cryosurgery
- ☐ Dermatologic Surgery
- ☐ Dilation and Curettage
- ☐ Ectopic Pregnancy
- ☐ Endometrial Ablation
- ☐ Gastrointestinal / Colon Surgery
- ☐ Gastrointestinal Bypass Surgery
- ☐ Gastrointestinal Surgery
- ☐ Genitourinary Surgery
- ☐ Graft
- ☐ Hysterectomy (ovaries remain)
- ☐ Hysterectomy with Oophorectomy (ovaries removed)
- ☐ Hysteroscopy
- ☐ Inguinal Hernia
- ☐ LEEP
- ☐ Laparoscopy
- ☐ Neurosurgery
- ☐ Laparotomy
- ☐ Maxillofacial Surgery
- ☐ Oncologic / Cancer Surgery
- ☐ Oophorectomy (ovary removal)
- ☐ Ophthalmologic Surgery
- ☐ Ophthalmology - Cataract Surgery
- ☐ Oral / Dental Surgery
- ☐ Orthopedic - Arthroscopic Surgery
- ☐ Orthopedic - Hip Replacement
- ☐ Orthopedic – Knee Replacement
- ☐ Orthopedic Surgery
- ☐ Otolaryngic (ENT) Surgery
- ☐ Ovarian Cystectomy
- ☐ Plastic / Reconstructive Surgery
- ☐ Pulmonary / Lung Surgery
- ☐ Splenectomy
- ☐ Thoracic / Chest Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Two unilateral mastectomies
- ☐ Urologic Surgery
- ☐ Vascular Surgery
- ☐ Vasectomy

Gynecology History

1. Date of LMP: ____/____/____
2. Frequency of Cycle: _____
3. Duration of Flow: _____
4. Flow: □ Light □ Moderate □ Heavy
5. Menses Monthly: □ Yes □ No
6. Menstrual Cramps: □ mild □ moderate □ severe
7. Premenstrual Syndrome: □ Yes □ No
8. Date of Last Pap Smear: ____/____/____
9. Date of HPV testing: ____/____/____
10. HPV testing: □ Positive □ Negative
11. Abnormal Pap: □ Yes □ No
12. Abnormal Pap Smear result: _____
    □ ASC-US □ ASC-H □ LSIL □ HSIL □ AGUS
13. Any Treatment for Abnormal Pap? □ Yes □ No
14. Colposcopy: ____/____/____
15. Age at Menarche: _____
16. If Post-Menopausal, Age at Menopause: _____
17. HPV Vaccine: □ Yes □ No
18. Sexual Orientation:
    □ Heterosexual □ Homosexual □ Bisexual □ Asexual
19. Number of Lifetime Sexual Partners: _____
20. Sexually Active? □ Yes □ No
21. Sexual Problems? □ Yes □ No
22. STIs/STDs: □ Yes □ No
23. Current Birth Control Method:
    □ None □ Condoms □ BCPs □ Depo-Provera □ Patch □ Vaginal Ring □ IUD □ Implant □ Withdrawal □Sterilization □ Tubal Ligation □ Partner Vasectomy □ Abstinence □ Spermicide □ Diaphragm □ Sponge □ Cervical Cap □ Multiple Methods □ Fertility Awareness Method □ Fertility Issues □ Breastfeeding/LAM □ Emergency Contraception □ Pregnant □ Seeking Pregnancy □ Ablation □ Menopause □ Hysterectomy □ Other
24. Desired Birth Control Method: _____
25. Date of Last Mammogram: ____/____/____
26. Mammogram Result: □ Normal □ Abnormal
27. Most Recent Bone Density: ____/____/____
28. Date of Last Colonoscopy: ____/____/____
29. Endometriosis: □ Yes □ No
30. Fibroids: □ Yes □ No
31. Infertility: □ Yes □ No
32. Ovarian Cyst: □ Yes □ No
33. PCOS: □ Yes □ No

Family History

Check all diseases and conditions that apply and list family member **(M**-Mother, **F**-Father, **Son**-Son, **D**-Daughter, **S**-Sister, **B**-Brother, **MGM**-Maternal, Grandmother, **MGF**-Maternal Grandfather, **MA**-Maternal Aunt, **MU**- Maternal Uncle, **O**-Other Relative, **PGM**-Paternal Grandmother, **PGF**-Paternal Grandfather, **PA**- Paternal Aunt, **PU**-Paternal Uncle**)**

- ❑ Addiction _____
- ❑ Anemia _____
- ❑ Anxiety disorder _____
- ❑ Arthritis _____
- ❑ Asthma _____
- ❑ Blood coagulation disorder _____
- ❑ Cerebrovascular accident/ **Stroke** _____
- ❑ COPD _____
- ❑ Cystic fibrosis _____
- ❑ Depressive disorder _____
- ❑ Developmental disorder_____
- ❑ Diabetes mellitus _____
- ❑ Disease of liver _____
- ❑ Disorder of cardiovascular system _____
- ❑ Disorder of endocrine system _____
- ❑ Disorder of gastrointestinal tract _____
- ❑ Disorder of lung _____
- ❑ Disorder of nervous system _____
- ❑ Disorder of the genitourinary system _____
- ❑ Disorder of thyroid gland _____
- ❑ Heart Disease _____
- ❑ Heart failure _____
- ❑ High Cholesterol _____
- ❑ High Blood Pressure _____
- ❑ Immunodeficiency disorder _____
- ❑ Kidney disease _____
- ❑ Uterine cancer _____
- ❑ Other Cancer _____
- ❑ Breast Cancer _____
- ❑ Cervical Cancer _____
- ❑ Colon Cancer _____
- ❑ Lung Cancer _____
- ❑ Ovarian cancer _____
- ❑ Stomach cancer _____
- ❑ Mental disorder _____
- ❑ Migraine/ Headaches _____
- ❑ Multiple sclerosis _____
- ❑ Myocardial infarction/ **heart attack** _____
- ❑ Obesity _____
- ❑ Osteoporosis _____
- ❑ Rheumatoid arthritis _____
- ❑ Seizure _____
- ❑ Tuberculosis _____

Social History

1. Do you have an Advance Directives to guide your healthcare in the event you are unable to make decisions?

   □ Yes □ No
2. Marital status: □ Unknown □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner
3. Do you feel safe in your current relationship? □ Yes □ No
4. Sexual orientation?

   □ Lesbian/ gay/ homosexual □ Straight/ heterosexual

   □ Bisexual □ Something else □ Don't know

   □ Choose not to disclose
5. Number of children: _____
6. Are you working: □ Yes □ No □ Retired □ Looking for work □ Disabled
7. Occupation: _____
8. On average, how many days per week do you engage in moderate to strenuous EXERCISE (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)? _____
9. On those days, how many minutes, on average, do you engage in EXERCISE at this level? _____
10. How often do you have a DRINK containing ALCOHOL?

    □ Never □ Monthly □ Less2-4 times a month

    □ 2-3 times a week □ 4 or more times a week
11. How often do you have six or more DRINKS on one occasion? □ Never □ Less than monthly □ Monthly

    □ Weekly □ Daily or almost daily
12. How many standard DRINKS containing alcohol do you have on a typical day? □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more
13. Illicit drugs: _____
14. Have you recently (within the last 12 weeks, or during a current pregnancy) traveled to or lived in a Zika-affected area: □ Yes □ No
15. Do you have symptoms associated with Zika virus (fever, rash, joint pain, or conjunctivitis)? □ Yes □ No
16. Are you currently sexually active with anyone who has traveled (within the last 12 weeks) to a Zika-affected area? □ Yes □ No
17. Are you planning to conceive with someone who has traveled (within the last 12 weeks) to a Zika-affected area? □ Yes □ No
18. Have you had sexual relations with anyone who has been positively diagnosed with Zika virus within the last 6 months? □ Yes □ No
19. Is blood transfusion acceptable in an emergency?

    □ Yes □ No
20. Chewing tobacco: □ None □ 1/day □ 2-4/day □ 5+/day
21. PCP completion date____/____/____
22. Smoking - How much? □ None □ 1 PPW □ 2 PPW □ 1/4 PPD □ 1/2 PPD □ 1 PPD □ 1 1/2 PPD □ 2 PPD □ 3+ PPD
23. Tobacco- years of use: _____
24. Tobacco Smoking Status: □ Never smoker □ Former smoker □ Current every day smoker □ Current some day smoker

    □ Smoker - status unknown □ Unknown if ever smoker

Obstetric History

Have you ever been pregnant? □Yes □No

How many times have you been pregnant? _____

Full Term_____ Premature_____ Miscarriages_____ Abortions_____ Ectopic_____ Multiples_____ Living children_____

Date	# Fetuses	Gestational age	Labor Length	Birth Weight	Sex	Delivery Type	Anesthesia	Complications
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		

Father/ Husband/ Domestic Partner: _____ Phone: _____

Pediatrician: _____ Phone: _____

Genetic Screening and Infection History

1. Patient's age will be 35 years or older at Estimated Date of Delivery ☐ Yes ☐ No
2. Thalassemia (Italian, Greek, Mediterranean, or Asian Background): MCV < 80 ☐ Yes ☐ No
3. Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly) ☐ Yes ☐ No
4. Congenital Heart Defect ☐ Yes ☐ No
5. Down Syndrome ☐ Yes ☐ No
6. Tay-Sachs (eg, Jewish, Cajun, French-Canadian) ☐ Yes ☐ No
7. Canavan Disease ☐ Yes ☐ No
8. Sickle Cell Disease or Trait (African) ☐ Yes ☐ No
9. Hemophilia or Other Blood Disorders ☐ Yes ☐ No
10. Muscular Dystrophy ☐ Yes ☐ No
11. Cystic Fibrosis ☐ Yes ☐ No
12. Huntington's Chorea ☐ Yes ☐ No
13. Mental Retardation/Autism ☐ Yes ☐ No
14. If yes, was person tested for Fragile X? ☐ Yes ☐ No
15. Other inherited genetic or chromosomal disorder ☐ Yes ☐ No
16. Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU) ☐ Yes ☐ No
17. Patient or Baby's Father had a child with birth defects not listed above ☐ Yes ☐ No
18. Recurrent pregnancy loss, or a stillbirth ☐ Yes ☐ No
19. Medications (including Supplements, Vitamins, Herbs, OTC Drugs), Illicit/ Recreational Drugs, Alcohol ☐ Yes ☐ No
20. If yes, agent(s) and strength/dosage _____
    _____
21. Any other Genetic History ☐ Yes ☐ No
22. Live with someone with TB or exposed to TB ☐ Yes ☐ No
23. Patient or partner has history of Genital Herpes ☐ Yes ☐ No
24. Rash or viral illness since last menstrual period ☐ Yes ☐ No
25. History of STD, Gonorrhea, Chlamydia, HPV, Syphilis ☐ Yes ☐ No
26. Other Infection History ☐ Yes ☐ No
27. Prior GBS-infected child ☐ Yes ☐ No
28. Neurologic (brain/spine) ☐ Yes ☐ No
29. History of Chicken Pox ☐ Yes ☐ No
30. Bloom Syndrome ☐ Yes ☐ No
31. History of HIV ☐ Yes ☐ No
32. Deafness/Blindness ☐ Yes ☐ No
33. Familial Dysautonomia ☐ Yes ☐ No
34. Hemochromatosis ☐ Yes ☐ No
35. Galactosemia ☐ Yes ☐ No
36. Bone/Skeletal Defects ☐ Yes ☐ No
37. History of Hepatitis ☐ Yes ☐ No
38. Developmental Delay ☐ Yes ☐ No
39. Marfan Syndrome ☐ Yes ☐ No
40. Niemann-Pick Disease ☐ Yes ☐ No
41. Color Blindness ☐ Yes ☐ No
42. Fanconi Anemia ☐ Yes ☐ No
43. Gaucher Disease ☐ Yes ☐ No
44. Dwarfism ☐ Yes ☐ No
45. Learning Problems ☐ Yes ☐ No
46. Polycystic Kidney Disease ☐ Yes ☐ No