Henderson Health Care/Sutton Family Practice

Obstetric Medical History

If you are uncomfortable answering any questions, leave them blank: you can discuss them with your doctor or nurse.

Personal Health History

1. Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

_____

2. Check any condition that you have or have had in the past:

☐ Cancer	☐ HIV/AIDS	☐ Diabetes	☐ Epilepsy	☐ Anemia
☐ Eating disorder	☐ Heart disease	☐ Headaches	☐ Depression	
☐ Arthritis or lupus	☐ Asthma	☐ Kidney disease	☐ Frequent infections	
☐ Hepatitis	☐ Bowel disease	☐ Herpes	☐ Sexually transmitted diseases	
☐ Recurrent urinary tract infections		☐ Thyroid disorder	☐ Blood clotting disorder (e.g. phlebitis)	
☐ von Willebrand's disease or other bleeding disorders			☐ High blood pressure	

Describe: _____

_____

3. List any surgery or hospitalization that you have had: _____

_____

_____

4. Describe any health problems or symptoms you are having at this time: _____

_____

_____

5. Do you or any family member have a history of problems with anesthesia? ☐ Yes ☐ No

If yes, please describe: _____

_____

Exposures Affecting Health

1. Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day? _____

If no, when did you quit?_____ How many packs per day? _____

2. Do you drink alcoholic beverages now or did you before you became pregnant? ☐ Yes ☐ No

If yes, how much and how often? _____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. Please list any illicit or recreational drugs used since your last period (e.g. cocaine, marijuana):_____

_____

5. Is there a chance you may have been exposed to AIDS (e.g., a history of blood transfusions, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)? ☐ Yes ☐ No

6. Are you ever exposed to chemicals or radiation (e.g., x-rays)? ☐ Yes ☐ No If yes, please describe: _____

_____

7. Are you on a restricted diet? ☐ Yes ☐ No If yes, please describe: _____

Gynecologic Health History

1. When was your last Pap test? _____

Have you ever had an abnormal Pap test? ☐ Yes ☐ No If yes, when and what treatment were you given? _____

_____

What was the diagnosis? _____

2. Have you ever had: ☐ gonorrhea ☐ chlamydia ☐ pelvic inflammatory disease If yes, when and what treatment were you given? _____

3. Have you ever had herpes? ☐ Yes ☐ No If yes, how often do you have outbreaks? _____

Have you ever had syphilis? ☐ Yes ☐ No If yes, how, when and where were you treated? _____

_____

4. Have you ever used an IUD (Intrauterine device) for contraception? ☐ Yes ☐ No If yes, when? _____

Did you have any problems with the IUD? ☐ Yes ☐ No If yes, please describe: _____

_____

5. Have you been treated for infertility? ☐ Yes ☐ No If yes, please describe when and what treatment you were given:

_____

6. Do you have any other concerns related to your past health history? ☐ Yes ☐ No If yes, please list: _____

_____

Family History and Genetic Screening

1. What is your ethnicity? _____What is the ethnicity of the baby's father? _____

2. Have you or has the baby's father had a child born with a birth defect? ☐ Yes ☐ No

If yes, please describe:_____

3. Did either you or the baby's father have a birth defect? ☐ Yes ☐ No

If yes, please describe:_____

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (e.g., mental retardation, birth defects, early infant death, deformities or inherited diseases such as hemophilia, muscular dystrophy or cystic fibrosis): _____

_____

_____

How is this child/person related to you? _____

5. Do you or does the baby's father have a history or 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? ☐ Yes ☐ No

Where was testing done and what were the results? _____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

Eastern European Jewish (Ashkenazi) ancestry ☐ Yes ☐ No

If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No Date_____ Result _____

If yes, have you had a Canavan screening test? ☐ Yes ☐ No Date_____ Result _____

If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No Date_____ Result _____

If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No Date_____ Result _____

African American ☐ Yes ☐ No

If yes, sickle cell screening ☐ Yes ☐ No Date_____ Result _____

Mediterranean ancestry or Southeast Asian ancestry ☐ Yes ☐ No

If yes, have you had screening for inherited forms of anemia such as thalassemia? ☐ Yes ☐ No

7. Please list any other concerns you have about birth defects or inherited disorders: _____

_____

_____

_____

_____

_____

8. Do you want to have a Down syndrome risk assessment? ☐ Yes ☐ No

9. Is the father 50 years or older? ☐ Yes ☐ No

Psychosocial Screening

1. Is there anything (job, transportation) that will prevent you from keeping your health care appointments? ☐ Yes ☐ No

2. Do you feel unsafe where you live? ☐ Yes ☐ No

3. Are you exposed to second-hand smoke? ☐ Yes ☐ No

4. In the past 2 months, have you used drugs or alcohol? (including beer, wine or mixed drinks) ☐ Yes ☐ No

5. In the past year, have you been threatened, hit, slapped or kicked by anyone you know? ☐ Yes ☐ No

6. Has anyone forced you to perform any sexual act that you did not want to do? ☐ Yes ☐ No

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? _____

_____ _____

Signature Date

_____

Printed name