PT'SNAME
DOB:

Associates For Women's Health- OB History

PERSONAL MEDICAL HISTORY				IF YES PLEASE PUT # AND EXPLAIN
1. Diabetes	Y/N	14.D (Rh) Sensitized	Y/N	
2. Hypertension	YN	15.Trauma/Violence	Y/N	
3. Heart Disease	Y/N	16. Drug/ Allergies	Y/N	
4. Autoimmune Disorder	Y/N	17. Breast	Y/N	
5. Kidney Disease/UTI	Y/N	18. Gynecologic Surgery	Y/N	
6. Neurologic/ Epilepsy	Y/N	19. Cancer	Y/N	
7. Psychiatric	Y/N	20. Bleeding Disorders	Y/N	
8. Depression/ PP Depression	Y/N	21. History of Abnormal Pap	Y/N	
9. Hepatitis/Liver Disease	Y/N	22. Uterine Anomalies	Y/N	
10. Blood Clotting Disease	Y/N	23. Infertility	Y/N	
11. Thyroid Dysfunction	Y/N	24. HIV/ AIDS	Y/N	
12. HX of Blood Transfusion	Y/N	25. Pulmonary (TB, Asthma)	Y/N	

Please indicate any Surgeries or Hospitalizations that you have had?

Please describe any Health Problems that you are having at this time?

Do you or any family members have a history of problems with Anesthesia? **Y/N**

Do you have any religious objections to any form of medical treatment? (ex blood transfusion) **Y/ N** If yes describe?

Do you Smoke? **Y / N** If Yes How many per Day? # of Years smoking-
If former smoker when did you quit?

Do you drink alcohol now or did you drink before you became pregnant? **Y / N** If Yes How often?
What type of drinks?

Please list any Illicit or Recreational Drugs used since your last period?

Are you ever exposed to Chemicals or Radiation?

Are you on a Restricted Diet? **Y/ N** If yes Describe-

Please list any Medications taken since your last period?

Have you been exposed to Aids? (ex- Intravenous drug use, multiple sexual partners, etc.)

Turn page over→

Genetic History	
Did either you or the baby's father have a birth defect? **Y/N** If yes Describe	
Have you or the Baby's father had a child with a birth defect? **Y/ N** if Yes Describe	
Please describe any abnormalities (if any) in children of your family or the baby's father's family? (ex deformities, mental retardation, Inherited diseases) How is this child related to you?	
Do you or does the baby father have a history of pregnancy losses (miscarriages or stillbirth) **Y/N** If yes, have either of you had genetic counseling? **Y/ N** **If yes When and Where?** If yes, have either of you had chromosomal testing? **Y/N** **If Yes When and Where?**	
What is your ethnicity?	What ethnicity is the baby's father?
Please check if you or the baby's father is of one of these background **European/Eastern European Jewish (Ashkenazi) ancestry** **Y/ N** If Yes, have you had Tay-Sachs screening test? **Y/ N** If Yes, have you had a Canavan Screening test? **Y/ N** If Yes, have you had a Cystic fibrosis Screening ? **Y/ N** If Yes, have you had familial Dysautomia Screening? **Y/ N**	**African American** **Y/ N** If yes have you had Sickle Cell Screening **Y/ N** If Yes Date- Result- **Mediterranean Ancestry or Southeast Asian Ancestry?** **Y/ N** If yes, have you had screening for inherited forms of anemia such as thalassemia? **Y/ N**
Do you want to have Down Syndrome Risk Assessment? **Y/N**	Is the baby's father 50 years or older? **Y/N**

Psychosocial Screening

Do you have any problems that prevent you from keeping your health care appts? Y/N	When was your last pap test? Result- If abnormal when and how were you treated?
Do you feel unsafe where you live?	Have you ever had: Gonorrhea □ Chlamydia □ Pelvic Inflammatory Disease □ If yes, when and where were you treated?
Are you exposed to second-hand smoke?	Have you ever had Herpes? Y/N If yes, how often do you get outbreaks?
In the past year have you been hit, slapped, or kicked by anyone you know? Y/N	Have you ever had syphilis? If yes, how, and where were you treated?
Has anyone forced you to perform any sexual acts that you did not want to do? Y/N	Have you been treated for infertility? Y/N If yes, please describe treatment.
On a scale of 1-5 how do you rate your current stress level?	Any other concerns?