

OBSTETRIC MEDICAL HISTORY

Patient Name _____

Date _____

•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 medication? Yes ____ No ____

If yes, please list: _____

2. Please mark any conditions that you have or have had in the past:

- Cancer _____
- Epilepsy _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney disease _____
- Hepatitis _____
- Blood clotting disorder (eg, phlebitis) _____
- Von Willebrand's disease or other bleeding disorders _____
- Sexually transmitted diseases _____
- Recurrent urinary tract infections _____
- HIV/AIDS _____
- Thyroid disorder _____
- Headaches _____
- Arthritis or lupus _____
- Frequent infections _____
- Bowel disease _____
- Diabetes _____
- Eating disorder _____
- Depression _____
- Asthma _____
- Anemia _____
- Herpes _____

Describe if needed:

3. Please indicate any surgery or hospitalization that you have had:

4. Please describe any health problems or symptoms that 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:

6. Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)? Yes ____ No ____ If yes, please describe:

EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? Yes ___ No ___

If yes, how many packs per day? _____

If former smoker, when did you quit? _____

2. Do you drink alcoholic beverages now or did you before you became pregnant? (1.5 oz spirits = 12 oz beer) Yes ___ No ___

If yes, how often? _____

What type of drinks? _____

3. Please list any medication 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 (eg, cocaine, marijuana):

5. Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, 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 (eg, X-rays)? Yes ___ No ___

If yes, please describe:

7. Are you on a restricted diet? Yes ___ No ___

If yes, please describe:

GYNECOLOGIC HISTORY

1. When was your last Pap test? _____

Have you ever had an abnormal Pap test? Yes ___ No ___

If yes, when and how were you treated?

What was the diagnosis? _____

2. Have you ever had:

Gonorrhea ___

Chlamydia ___

Pelvic inflammatory disease ___

If yes, when, how and where were you treated?

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, please indicate 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 treatment received:

6. Do you have any other concerns related to your past health history?

FAMILY HISTORY & 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 (eg, 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 of 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 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, one of these backgrounds:

Eastern European Jewish (Ashkenazi) ancestry? Yes _____ No _____

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

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

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

Date: _____ Result: _____

African American? Yes _____ No _____

If yes, have you had sickle cell screening? Yes _____ No _____

Date: _____ Result: _____

European Ancestry & Eastern European Jewish (Ashkenazi) ancestry? Yes _____ No _____

If yes, have you had cystic fibrosis 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 ___

PSYCHOLOGICAL SCREENING

1. Do you have any problems (job, transportation etc.) that 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 two months, have you used drugs or alcohol (including beer, wine & 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 (1 being low, 5 being high) how do you rate your stress level? ___

8. How many times have you moved in the past 12 months? _____

*MODIFIED AND REPRINTED WITH PERMISSION FROM FLORIDA'S HEALTHY START PRENATAL RISK SCREENING INSTRUMENT. FLORIDA DEPARTMENT OF HEALTH. DH 3134. SEPTEMBER 1997

Patient Signature

Print Name

Date