DATE:_____ NAME:_____ D.O.B._____ AGE:_____

BP: P: PO2: HT: WT: BMI: TEMP:

If your name, address, phone number, or emergency contact has changed since your last visit please note changes here:
☐No Changes

What is the reason for your visit today? If here for a problem, is this a new problem? ☐YES ☐NO

If here for a problem, where is it, how severe is it, when did it start?

If here for a problem, what makes it better, what makes it worse?

Have you been treated for this problem before? ☐YES ☐NO
If yes, where/when?

Date of first day of last menstrual period?
☐Hysterectomy ☐Menopause ☐Mirena/Skyla ☐Uterine Ablation

Date of last Pap smear? Date of last mammogram? Date of last Colonoscopy?

CURRENT MEDICATIONS: List prescriptions, hormones, vitamins, herbs, non-prescription medications & supplements

Name of Medication	Dose & How often used	Month & Year Began Taking	Who Prescribed

CURRENT BIRTH CONTROL:

☐None ☐Seeking pregnancy or pregnant ☐Abstained ☐Withdrawal ☐Condoms ☐Outer-course (no penetration)
☐Condoms ☐Vasectomy ☐Tubal Ligation/Essure ☐Natural family planning - rhythm ☐Diaphragm ☐Injection/Shot
☐Pills ☐Patch ☐Ring ☐Implant: Implanon/Nexplanon ☐IUD: Mirena/Skyla/Paragard

ALLERGIES: LIST ALL ALLERGIES TO MEDICATIONS AND FOOD

☐No Known Allergies
☐YES, I am allergic to LATEX
☐YES, see my list of allergies and reactions below

Allergic To:	Reaction:

FAMILY MEDICAL HISTORY:

Circle your family members below who have any of the following conditions:
☐Check here if adopted and your family history is unknown

DIAGNOSIS	RELATIVE(S) WITH THIS ILLNESS	AGE of onset
Diabetes	Mother Father Sibling Grandparent Other:	
Stroke	Mother Father Sibling Grandparent Other:	
Blood clotting disorder	Mother Father Sibling Grandparent Other:	
Heart Disease	Mother Father Sibling Grandparent Other:	
High Blood Pressure	Mother Father Sibling Grandparent Other:	
High Cholesterol	Mother Father Sibling Grandparent Other:	
Mental Illness	Mother Father Sibling Grandparent Other:	
Depression	Mother Father Sibling Grandparent Other:	
Alcohol or Drug Abuse	Mother Father Sibling Grandparent Other:	
Osteoporosis	Mother Father Sibling Grandparent Other:	
Birth Defect	Mother Father Sibling Grandparent Other:	
HIV/AIDS	Mother Father Sibling Grandparent Other:	
Tuberculosis	Mother Father Sibling Grandparent Other:	
Hepatitis	Mother Father Sibling Grandparent Other:	
Alzheimer's (dementia)	Mother Father Sibling Grandparent Other:	

Breast Cancer	Mother Father Sibling Grandparent Other:	
Ovarian or Uterine Cancer	Mother Father Sibling Grandparent Other:	
Colon cancer	Mother Father Sibling Grandparent Other:	
Other:	Mother Father Sibling Grandparent Other:	

Past Menstrual History:

Heavy flow? Y / N **How many days does your period last?** **How often is your cycle?**

YES	NO	PAST SURGICAL HISTORY:
		Have you ever been hospitalized overnight? If yes, list dates and reasons for hospitalization:

YES	NO	Have you ever had surgery? If yes, list dates and surgeries (include breast surgery and ablations):

Date:	Name:	DOB:	Age:
ER Contact Person:	Relationship/Age:	Phone:	

OBSTETRIC HISTORY

Total Number of Pregnancies	Number of Full Term Births (37-42 weeks)	Number of Preterm Births (20-36 weeks)	Number abortions, miscarriage, ectopic (Before 20 weeks)	Number of Living Children

DETAILS OF PREGNANCIES

No.	Date	# Weeks Pregnant	Type of Delivery	# Hours Labor	Baby's Weight	Baby's Sex	Type of Anesthesia	Place of Delivery	Complications
1									
2									
3									
4									
5									
6									

GENETIC SCREENING QUESTIONS

YES	NO	Include yourself (the patient), the baby's father, and anyone in either family
		Are you going to be age 35 or older at the time of your due date
		Anyone have Thalassemia or is Italian, Greek, Mediterranean, or Asian
		Anyone born with a neural tube defect (Meningomyelocele, Spina Bifida, or Anacephaly)
		Anyone have a congenital heart defect
		Anyone with Down's Syndrome
		Anyone with Tay-Sachs or is Jewish, Cajun, French, Canadian
		Anyone with Canavan Disease
		Anyone with Sickle Cell Trait, Sickle Cell Disease, or is African
		Anyone with Hemophilia, Hemochromatosis, or other blood or clotting disorder
		Anyone with Muscular Dystrophy or Spinal Muscular Atrophy (SMA)
		Anyone with Cystic Fibrosis
		Anyone with Huntington's Chorea
		Anyone with Mental Retardation or Autistic Spectrum Disorder
		Anyone with Fragile X
		Any other inherited genetic or chromosomal disorder? If yes, what:
		Anyone with metabolic disorder (e.g. Type 1 or Insulin Dependent Diabetes) or PKU
		You (the patient) or Baby's father has already had a child with birth defects
		You have had recurrent pregnancy losses or stillbirth
		You used medications, recreational drugs, or alcohol during this pregnancy? If yes, what:
		Testing for Cystic Fibrosis gene mutations is recommended – are you interested in having the test done?
		You will be counseled & offered CORD BLOOD BANKING – are you interested in cord blood banking?
		In an emergency, would you REFUSE a blood transfusion due to religious or other beliefs?

YES	NO	INFECTION HISTORY QUESTIONS
		Are you at high risk for exposure to HIV / AIDS?
		Are you at high risk for exposure to Hepatitis B?
		Do you live with someone who has Tuberculosis (TB) or have you been exposed to TB?
		Do you have a personal history of genital herpes (HSV2) or sex partner who has genital herpes?
		Have you had a rash or viral illness since becoming pregnant?
		Have you ever had a sexually transmitted infection? HPV, Chlamydia, Trichomonas, Gonorrhea, Syphilis,
		Have you had any other infection not listed above? If yes, what?