HEALTH HISTORY FORM

NAME: _____BIRTHDATE:_____AGE: _____
PARTNER'S NAME: _____BIRTHDATE:_____AGE: _____
MARITAL STATUS: (circle) Single, Married, Widow, Divorced, Separated
ARE YOU CURRENLTY PREGNANT? ☐ Yes ☐ No
ARE YOU PLANNING TO GET PREGNANT IN THE NEXT SIX MONTHS? ☐ Yes ☐ No
WHO IS YOUR PRIMARY CARE DOCTOR? _____
DO YOU HAVE AN OB/GYN? ☐ Yes ☐ No If yes (name) _____
WHEN WAS THE LAST TIME YOU SAW A DOCTOR AND FOR WHAT? _____

Patient's Medical History	Family Medical History (please indicate who has condition)
☐ Neurologic/Epilepsy	☐ Neurologic/Epilepsy _____
☐ Tuberculosis	☐ Tuberculosis _____
☐ Diabetes	☐ Diabetes _____
☐ Asthma/pulmonary	☐ Asthma/pulmonary _____
☐ High blood pressure	☐ High blood pressure _____
☐ Heart disease	☐ Heart disease _____
☐ Anemia	☐ Anemia _____
☐ Kidney or bladder disorders	☐ Kidney or bladder disorders _____
☐ Thyroid disease	☐ Thyroid disease _____
☐ Hepatitis/liver disease	☐ Hepatitis/liver disease _____
☐ Varicosities/phlebitis/blood clotting disorder	☐ Varicosities/phlebitis/blood clotting disorder_____
☐ Digestive problems	☐ Digestive problems _____
☐ Depression or other mental illness	☐ Depression or other mental illness _____
☐ Auto immune disorder /Lupus	☐ Auto immune disorder /Lupus _____
☐ Scleroderma	☐ Scleroderma _____
☐ History of blood transfusion	☐ History of blood transfusion _____
☐ Rh sensitized	☐ Rh sensitized _____
☐ Infection to resistant organism (i.e. MRSA, VRE)	☐ Infection to resistant organism (i.e. MRSA, VRE)
☐ Other conditions:	☐ Other conditions:
_____	_____
_____	_____
☐ Hospitalizations (year and reason)	_____
_____	_____
_____	_____

Physician comments:

How many total pregnancies have you had? _____ Pregnancy Due Date_____ GA: _____

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Please list all past pregnancies in order from first to last. Include miscarriages and abortions.

Year	How many weeks or months when delivered	Length of labor	Birth weight	Sex M/F	Vaginal delivery or Cesarean section? If loss, did you have a D&C?	Epidural or Spinal	Place of Delivery	Preterm labor (Y/N)	Comments/complications

What is the first day of your last menstrual cycle? _____(circle) definite, approximate, unknown

☐ Yes ☐ No Do you have any problems with your menstrual cycle?

☐ Yes ☐ No Do you have monthly menses? Every _____ days, lasting _____ days.

☐ Yes ☐ No Have you ever had an abnormal PAP? Last PAP date: _____

☐ Yes ☐ No Do you have difficulty getting pregnant?

☐ Yes ☐ No Have you been treated for infertility?

☐ Yes ☐ No Is this an IVF pregnancy?
Date of egg retrieval: _____ Date of embryo transfer _____ # of embryos _____

☐ Yes ☐ No Have you ever had a miscarriage? How many _____ How far along were you? _____

☐ Yes ☐ No Have you ever had a preterm birth? How early? _____

☐ Yes ☐ No Have you ever been told you have an unusual shaped uterus? What shape? _____

☐ Yes ☐ No Have you had surgery on your uterus, cervix, ovaries or fallopian tubes? (circle)

☐ Yes ☐ No Did your mother take the hormone DES during pregnancy?

☐ Yes ☐ No Have you ever been diagnosed with HPV, genital warts, chlamydia, herpes, gonorrhea, syphilis, HIV/AIDS other (circle) When: _____

☐ Yes ☐ No Have you ever had a cesarean section? How many? _____ What type of incision do you have?

_____

Physician comments:

Surgical History

☐ Yes ☐ No Have you ever had surgery? List surgery and date: _____

_____

☐ Yes ☐ No Have you or any family member had complications with anesthesia? List: _____

_____

Physician comments:

Genetics

Do you, your partner, or either of your families have a history of:

• Hemophilia or other blood disorders	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Thalassemia (Italian, Greek, Mediterranean or Asian background)	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Tay-Sachs disease	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Canavan disease	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Sickle cell disease or trait	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Muscular dystrophy	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Neurofibromatosis	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Polycystic kidney disease	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Cystic fibrosis	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Huntington ’s chorea	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Down Syndrome	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Cleft lip or palate: _____	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Mental retardation/autism: _____	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Birth defects (spine, heart, kidney): _____	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Other inherited genetic or chromosomal disorder	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Maternal metabolic disorders (Type I diabetes, PKU)	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Blindness/deafness	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Have you had any screening for genetic disorders in the past?	☐ No ☐ Yes If yes please indicate: YOU PARTNER
• Are you or your partner from any one of the following ethnic backgrounds? (circle) Chinese, Taiwanese, Asian Indian, Pakistani, Filipino, Pacific Islander, Southeast Asian, Italian, Greek, Middle Eastern, Spanish, Portuguese, Jewish, French Canadian, Cajun, African American, African descent, Puerto Rican, Caribbean, Central American.	☐ No ☐ Yes If yes please indicate: YOU PARTNER

If not from one of the above, please list ethnic background here: _____
Physician comments:

Medication and Drugs

Drug allergies ☐ Yes ☐ No known drug allergies
List allergies: _____ Reaction: _____
Food or environmental allergies: List: _____ Reaction:_____
Latex allergy ☐ Yes ☐ No If yes, list reaction _____
☐ Yes ☐ No Are you taking any prescription drugs? **Please list medication, dose and frequency**: _____
_____
☐ Yes ☐ No Are you taking prenatal vitamins daily?
☐ Yes ☐ No Are you taking additional folic acid daily? If yes, what dose? _____
☐ Yes ☐ No Are you taking any over the counter medications including other vitamins, minerals, herbs, traditional remedies, weight loss products or sports supplements? List them: _____
_____

Diet and Exercise

What do you consider a healthy weight for you? _____
How tall are you? _____ How much do you weigh? _____
Which do you drink? (circle) coffee, tea, cola, milk, water, other soda/pop, other: _____
☐ Yes ☐ No Do you eat 3 meals a day?
☐ Yes ☐ No Do you eat raw or undercooked meat or fish?
☐ Yes ☐ No Do you eat aged cheeses?
☐ Yes ☐ No Do you have current/past problems with eating disorders?
☐ Yes ☐ No Do you exercise? Type: _____ Frequency: _____
Physician comments:

Lifestyle

☐ Yes ☐ No Do you smoke cigarettes or use other tobacco products? How many per day? _____
☐ Yes ☐ No Are you exposed to second-hand smoke?
☐ Yes ☐ No Do you drink alcohol? What kind? _____ How much? _____ How often? _____
☐ Yes ☐ No Do you use recreational drugs including cocaine, heroin, ecstasy, meth/ice, other? (circle)
How much? _____ How often? _____ Last used: _____
☐ Yes ☐ No Do you see a dentist regularly?
☐ Yes ☐ No Do you live near or work with possible hazards including chemical, x-ray or other radiation, lead, other? (circle) Please explain: _____
☐ Yes ☐ No Do you use saunas or hot tubs?
What kind of work do you do?_____
What kind of work does your partner do? _____
☐ Yes ☐ No Is a blood transfusion acceptable in an emergency?

Physician comments:

Home Environment

☐ Yes ☐ No Do you feel emotionally supported at home?
☐ Yes ☐ No Do you have help from friends or relatives if needed?
☐ Yes ☐ No Do you feel you have serious money/financial worries?
☐ Yes ☐ No Do you have pets (cats, rodents, exotic animals)? Please list: _____
☐ Yes ☐ No Are you in a stable relationship?
☐ Yes ☐ No Do you feel safe at home?
☐ Yes ☐ No Does anyone threaten or physically hurt you? If yes, who? _____
☐ Yes ☐ No Are you currently in counseling for domestic violence related issues?

What are your concerns about pregnancy?

Physician comments:

VACCINATION HISTORY

			Date
☐ Yes	☐ No	Have you ever had chicken pox?	_____
☐ Yes	☐ No	Varicella vaccine (once if not immune)	_____
☐ Yes	☐ No	Tetanus–diphtheria booster (every 10 years)	_____
☐ Yes	☐ No	Measles, mumps, rubella (once if not immune)	_____
☐ Yes	☐ No	Human papillomavirus (once, age 9-26)	_____
☐ Yes	☐ No	Hepatitis B vaccine	_____
☐ Yes	☐ No	Influenza vaccine	_____

REVIEW OF SYSTEMS

Have you had any of the following symptoms?

☐ Yes	☐ No	Fever, chills or fatigue
☐ Yes	☐ No	Vision problems or pain in eyes
☐ Yes	☐ No	Headache, sore throat, ear ache
☐ Yes	☐ No	Palpitations or chest pain
☐ Yes	☐ No	Cough, shortness of breath or runny nose
☐ Yes	☐ No	Burning or frequency urination, abnormal bleeding or discharge
☐ Yes	☐ No	Diarrhea or constipation
☐ Yes	☐ No	Muscle aches, joint aches
☐ Yes	☐ No	Numbness or weakness
☐ Yes	☐ No	Rash or lesions
☐ Yes	☐ No	Thoughts of suicide, recent trauma

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Constitutional	☐ Negative	☐ Positive
Vision	☐ Negative	☐ Positive
ENT:	☐ Negative	☐ Positive
Cardiovascular:	☐ Negative	☐ Positive
Respiratory:	☐ Negative	☐ Positive
GU:	☐ Negative	☐ Positive
GI:	☐ Negative	☐ Positive
Musculoskeletal:	☐ Negative	☐ Positive
Neuro:	☐ Negative	☐ Positive
Skin:	☐ Negative	☐ Positive
Other:	☐ Negative	☐ Positive

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Vital Signs: T: _____ P: _____ BP: _____ R: _____

Urine dip: Protein _____ Glucose _____

Weight: _____ Height: _____