Westside Obstetrics & Gynecology
Obstetrical Medical History

Patient Name: ____

Date Form Completed: _______________________________________

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

PERSONAL HEALTH HISTORY

1. ☐ Yes ☐ No Are you allergic to any medications?

If yes, please list:

____

____

____

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

☐ Cancer	☐ HIV/AIDS	☐ Diabetes
☐ Epilepsy	☐ Thyroid disorder	☐ Eating disorder
☐ Heart disease	☐ Headaches	☐ Depression
☐ High blood Pressure	☐ Arthritis or lupus	☐ Asthma
☐ Kidney disease	☐ Frequent infections	☐ Anemia
☐ Hepatitis	☐ Bowel disease	☐ Herpes

☐ von Willebrand's disease or other bleeding disorders ☐ Sexually transmitted diseases

☐ Blood clotting disorder (e.g. phlebitis) ☐ Recurrent urinary tract infections

Describe, if needed:

____

____

____

3. Please indicate any surgery that you have had:

____

____

____

____

4. Please describe any health problems or symptoms that you are having at this time:

____

____

____

5. ☐ Yes ☐ No Do your or any family member have a history of problems with anesthesia?
If yes, please describe:

____

____

____

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

____

____

____

OBSTETRICAL HISTORY

Please complete the following table about your previous pregnancies in chronological order.
Please date all pregnancies including miscarriages.

No	Month/Year	Sex	Weight	Weeks at Delivery	Hours in Labor	Type of Delivery	Baby's Name	Problems
1								
2								
3								
4								
5								
6								
7								

MENSTRUAL HISTORY

Date of Last Period _______________________ Date of Period prior to last period _____________________

Was it normal? ☐ Yes ☐ No

How many days between the start of one period to the start of the next? ____________________

Did you use any contraception? ☐ Yes ☐ No Date of last use:

____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? ________________________________

☐ Yes ☐ No Have you ever had an abnormal Pap Test?
If yes, when and how were you treated? ____

____

What was the diagnosis?

____

2. ☐ Yes ☐ No Have you ever had gonorrhea ☐, chlamydia ☐, or pelvic inflammatory disease ☐ ?

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

3. ☐ Yes ☐ No Have you ever had herpes?

If yes, how often do you have outbreaks? ____

☐ Yes ☐ No Have you every had syphilis?

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

4. ☐ Yes ☐ No Have you ever used an IUD (intrauterine device) for contraception?

If yes, please indicate when:

____

☐ Yes ☐ No Did you have any problem with the IUD?

If yes, please describe:

____

5. ☐ Yes ☐ No Have you been treated for infertility?

If yes, please describe when and treatment received: ___________________________________

____

6. ☐ Yes ☐ No Do you have any other concerns related to your past health history?

If yes, please list:

____

____

EXPOSURES AFFECTING HEALTH

1. ☐ Yes ☐ No Do you smoke cigarettes?

If yes, how many packs per day? _____________________

EXPOSURES AFFECTING HEALTH (continued)

2. ☐ Yes ☐ No Do you drink alcoholic beverages?

If yes, 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. ☐ Yes ☐ No Do you have any reason to believe you may have been exposed to AIDS (e.g., 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)?

6. ☐ Yes ☐ No Are you ever exposed to chemicals or radiation (e.g., X-rays)?

If yes, please describe:

____

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

If yes, please describe:

____

FAMILY HISTORY & GENETIC SCREENING

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

If yes, please describe:

____

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

If yes, please describe:

____

3. 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, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

____

____

4. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)?

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?

____

5. 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:

☐ Yes ☐ No Eastern Europe Jewish ancestry

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

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

Date ____________________ Result

____

☐ Yes ☐ No African American

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

Date ____________________ Result

____

☐ Yes ☐ No European Ancestry

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

☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry

If yes, have you had screening for inherited forms of anemia such as thalassemia

☐ Yes ☐ No

FAMILY HISTORY & GENETIC SCREENING (continued)

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

____

____

____

____

7.	☐ Yes	☐ No	Will you be 35 years or older at the time the baby is born?
8.	☐ Yes	☐ No	Will the father be 50 years or older?

PSYCHOSOCIAL SCREENING			
1.	☐ Yes	☐ No	Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
2.	☐ Yes	☐ No	Do you feel unsafe where you live?
3.	☐ Yes	☐ No	In the past 2 months, have you used any form of tobacco?
4.	☐ Yes	☐ No	In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks?
5.	☐ Yes	☐ No	In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6.	☐ Yes	☐ No	Has anyone forced you to perform any sexual act that you did not want to do?
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?
9.	☐ Yes	☐ No	Is this a planned pregnancy?
	☐ Yes	☐ No	Is this a wanted pregnancy?

____

Patient Signature

____

Print name

____

Date