UP HEALTH SYSTEM BELL

Patient Label

901 Lakeshore Dr., Ishpeming, MI 49849

OBSTETRIC MEDICAL HISTORY

NAME: _____
LAST FIRST MIDDLE

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. Have you ever had an allergic reaction to a medication or vaccine component? ❑ Yes ❑ No
   a. If yes, please list: _____
   b. Any other allergies or reactions? _____
2. Please mark any condition that you have or have had in the past:

❑ Epilepsy	❑ Anemia	❑ Kidney Disease	❑ Heart Disease
❑ Headaches	❑ Gestational Diabetes	❑ Cancer	❑ HIV/AIDS
❑ Thyroid Disorder	❑ High Blood Pressure	❑ Arthritis or Lupus	❑ Frequent Infections
❑ Breast Disease	❑ Blood Transfusion	❑ Skin Disorders	❑ Psychiatric Illness
❑ Asthma	❑ Gastrointestinal Illness	❑ Prior Preterm Birth	❑ Herpes
❑ Tuberculosis	❑ Hepatitis	❑ Eating Disorder	❑ Other: _____
❑ Recurrent Urinary Tract Infections	❑ Sexually Transmitted Infections	❑ Diabetes (Type 1 or Type 2)	
❑ von Willebrand disease or other bleeding disorders	❑ Blood Clotting Disorder (e.g. Phlebitis/ Thrombophilia)	❑ Group B Streptococcus in Prior Pregnancy	❑ Depression/ Postpartum Depression

   Describe, if needed: _____
3. Please indicate any surgery or hospitalization you have had, and the date it occurred:
   _____
   _____
4. Please describe any health problems or symptoms that you are having at this time:
   _____
5. Do you or any of your family members have a history of problems with anesthesia? ❑ Yes ❑ No
   If yes, please describe: _____
6. Do you have any objections to any form of medical treatment (e.g. blood transfusion)? ❑ Yes ❑ No
   If yes, please describe: _____

EXPOSURES AFFECTING HEALTH

1. Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped? ❑ Yes ❑ No
   If yes, how many packs per day? _____ If former smoker/user, when did you quit? _____

2. Do you drink alcoholic beverage now?
   ❑ Yes ❑ No If yes, please indicate number of drinks per week: _____
   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. Have you used any street drugs since your last menstrual period (e.g. cocaine, marijuana, opioids)?
   ❑ Yes ❑ No If yes, please indicate number of uses per week: _____
   What time of drugs? _____

5. Do you have any reason to believe you or your partner have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs? ❑ Yes ❑ No

6. Have you been exposed to chemicals (e.g. pesticides, lead hazardous material/agents) or radiation (e.g. x-rays) since you became pregnant? ❑ Yes ❑ No
   If yes, please describe: _____

7. Are you on a restricted diet? ❑ Yes ❑ No
   If yes, please describe: _____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____

2. Have you received all three doses of the HPV vaccine? ❑ Yes ❑ No

3. Have you ever had an abnormal Pap test? ❑ Yes ❑ No
   If yes, when and how were you treated? _____
   What was the diagnosis? _____

4. Have you ever had HPV? ❑ Yes ❑ No

5. Have you ever had ❑ Gonorrhea ❑ Chlamydia ❑ Pelvic Inflammatory Disease? ❑ Yes ❑ No
   If yes, when, how and where were you treated? _____

6. Have you ever had herpes? ❑ Yes ❑ No
   If yes, where do you have outbreaks, and how often? _____

Gynecological Health History (cont'd)

7. Have you ever had syphilis? ❑ Yes ❑ No
   If yes, how, when and where were you treated? _____

8. Have you ever used an intrauterine device (IUD) for contraception? ❑ Yes ❑ No
   If yes, please indicate when? _____
   Did you have any problem with the IUD? ❑ Yes ❑ No
   If yes, please describe: _____

9. Have you been treated for infertility? ❑ Yes ❑ No
   If yes, please describe when and treatment received: _____

10. Do you have any other concerns related to your past health history? ❑ Yes ❑ No
    If yes, please list: _____

PRIOR PREGNANCIES

Date of Birth	How many weeks when delivered	Length of Labor	Complications	Facility where delivered

FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity? _____

2. What is the ethnicity of the baby's father? _____

3. Have you or has the baby's father had a child born with a birth defect? ❑ Yes ❑ No
   If yes, please describe: _____

4. Please describe any special needs that have occurred in children in your family or the baby's father's family (e.g. cognitive impairment/intellectual disability, 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 loses (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

If yes, where and what were the results? _____

Family History & Genetic Screening (cont'd)

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, of one of these backgrounds:
   ☑ Eastern European Jewish (Ashkenazi) Ancestry ❑ Yes ❑ No
   If yes, have you had tay-sachs screening tests? ❑ Yes ❑ No ❑ Unsure
   If yes, have you had a canavan screening test? ❑ Yes ❑ No ❑ Unsure
   If yes, have you ad familial dysautonomia screening? ❑ Yes ❑ No ❑ Unsure
   Date: _____/_____/_____ Result: _____

7. African American ❑ Yes ❑ No
   If yes, have you had sickle cell screening? ❑ Yes ❑ No
   Date: _____/_____/_____ Result: _____

8. Mediterranean Ancestry or Southeast Asian Ancestry ❑ Yes ❑ No
   If yes, have you had screening for inherited forms of anemia such as Thalassemia? ❑ Yes ❑ No

9. French Canadian or Cajun Ancestry ❑ Yes ❑ No
   If yes, have you had Tay-Sachs screening tests? ❑ Yes ❑ No

10. Have you had cystic fibrosis screening? ❑ Yes ❑ No
11. Have you had any other genetic carrier screening, such as an expanded carrier screening?
    ❑ Yes ❑ No
    Date: _____/_____/_____ Screening: _____ Result: _____

PSYCHOSOCIAL SCREENING

1. Do you have any problems (e.g. job, transportation) 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 year, have you been threatened, hit, slapped, or kicked by anyone you know?
   ❑ Yes ❑ No
5. On a scale of 1-5, how do you rate your current stress level? Low 1 2 3 4 5 High
6. How many times have you moved in the past 12 months? _____

_____ _____

Patient Signature Printed Name Date/Time