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 Infections ☐ Sexually Transmitted Infections (Type 1 or Type 2)
   ☐ von Willebrand disease or other bleeding disorders Describe, if needed:

   ☐ Tract Infections ☐ Blood Clotting Disorder (e.g. Phlebitis/Thrombophilia)
   ☐ Group B Streptococcus in Prior Pregnancy ☐ Depression/Postpartum Depression

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: _______________________________________________________

Obstetric Medical History Revised 4-17-18
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

<table>
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<tr>
<th>Date of Birth</th>
<th>How many weeks when delivered</th>
<th>Length of Labor</th>
<th>Complications</th>
<th>Facility where delivered</th>
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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

Obstetric Medical History Revised 4-17-18