

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. Yes No Have you ever had an allergic reaction to a medication or vaccine component?

If yes, please list: _____

Any other allergies or reactions? _____

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Recurrent Urinary Tract Infections | <input type="checkbox"/> Sexually Transmitted Infections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> von Willebrand disease or other bleeding disorders | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Blood Clotting Disorder (eg, Phlebitis/Thrombophilia) | <input type="checkbox"/> Diabetes (Type 1 or Type 2) | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Arthritis or Lupus | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal Illness | <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Depression/Postpartum Depression |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prior Preterm Birth | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Group B Streptococcus In Prior Pregnancy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Cancer | | | |

Describe, if needed: _____

3. Please indicate any surgery or hospitalization that you have had and the date:

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

5. Yes No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. Yes No Do you have any objections to any form of medical treatment (eg, blood transfusion)?

If yes, please describe: _____

Exposures Affecting Health

1. Yes No Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped?
If yes, how many packs per day? _____ If former smoker/user, when did you quit? _____
2. Yes No Do you drink alcoholic beverages now or did you before you became pregnant?
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. Yes No Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)?
If yes, please indicate number of uses per week: _____
What type of drugs? _____
5. Yes No Do you have any reason to believe you or your partner may 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?
6. Yes No Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant?
If yes, please describe: _____
7. Yes No Are you on a restricted diet?
If yes, please describe: _____

Gynecologic Health History

1. When was your last Pap test? _____
 Yes No Have you received all three doses of the HPV vaccine?
 Yes No Have you ever had an abnormal pap test?
If yes, when and how were you treated? _____

What was the diagnosis? _____
 Yes No Have you ever had HPV?
2. Yes No Have you ever had Gonorrhea Chlamydia Pelvic Inflammatory Disease
If yes, when, how, and where were you treated? _____
3. Yes No Have you ever had herpes?
If yes, where do you have outbreaks? _____
If yes, how often do you have outbreaks? _____
 Yes No Have you ever had syphilis?
If yes, how, when, and where were you treated? _____
4. Yes No Have you ever used an intrauterine device (IUD) 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: _____

Family History & Genetic Screening

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

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

3. Yes No Did either you or the baby's father have a birth defect?
If yes, please describe: _____

4. Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, 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. Yes No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?
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? _____

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:

Yes No Eastern European Jewish (Ashkenazi) Ancestry
If yes, have you had tay-sachs screening tests? Yes No
If yes, have you had a canavan screening test? Yes No
If yes, have you had familial dysautonomia screening? Yes No
Date: ____/____/____ Result: _____

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

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

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

7. Yes No Have you had cystic fibrosis screening?

8. Yes No Have you had any other genetic carrier screening, such as an expanded carrier screening?
Screening: _____ Date: ____/____/____ Result: _____

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

10. Yes No Do you want a test that will tell you about your risk to have a baby with Down syndrome?

11. Yes No Is the father 45 years or older?

Psychosocial Screening*

- 1. Yes No Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?
- 2. Yes No Do you feel unsafe where you live?
- 3. Yes No Are you exposed to second-hand smoke? Yes No In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped?
- 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. If you could change the timing of this pregnancy, would you want it earlier later not at all/NA

*Modified and reprinted with permission from Florida’s Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

PATIENT SIGNATURE

PRINT NAME

DATE

Notes
