Patient name_____ Account Number_____

MEDICAL HISTORY FORM OBSTETRICAL PATIENTS

The following information is important for your obstetrical care. Please complete the front and back of this form.

Personal Medical History

Yes	No	
		Do you..
☐	☐	1. Have diabetes or did you ever have gestational diabetes?
☐	☐	2. Have a seizure disorder or epilepsy?
☐	☐	3. Have kidney disease?
☐	☐	4. Or the father of the baby have a history of treatment for cancer?
☐	☐	5. Have rheumatoid arthritis, systemic lupus or other auto immune disease?
☐	☐	6. Have a history of PKU ?
☐	☐	7. Have a history of herpes (genital or oral)?
		Have you…
☐	☐	8. Had a stillbirth or more than one miscarriage/pregnancy loss?
☐	☐	9. Been diagnosed or treated for depression or anxiety?
		If yes: What medications have you used in the past? _____
		When were you last treated? _____
☐	☐	10. Received the Varicella vaccine or had chicken pox or shingles?
☐	☐	11. Or the father of the baby traveled to Mexico, the Caribbean, Central or South America in the last 3 months?
		If so: when? _____

Family History

☐	☐	12. Are you or the father of the baby: ☐ Jewish ☐ Black ☐ Mediterranean descent?
☐	☐	13. Are you and the father of the baby blood relatives?

Please check any of the following genetic disease that might be in your family

☐ Anencephaly (open skull)	☐ Kidney disease
☐ Blindness or disorders of the eye	☐ Limb defects
☐ Bone disorder	☐ Malformation or birth defects
☐ Cerebral palsy	☐ Mental illness
☐ Chromosome abnormality	☐ Mental retardation
☐ Cleft lip/palate	☐ Neurofibromatosis
☐ Cystic fibrosis	☐ Neurologic disorder
☐ Deafness	☐ Short stature (under 5 ft)
☐ Down's syndrome	☐ Sickle cell anemia
☐ Duchenne muscular dystrophy	☐ Skeletal problems
☐ Epilepsy/seizures	☐ Spina Bifida
☐ Fragile X Syndrome	☐ Spinal muscular atrophy
☐ Heart defect	☐ Tay Sachs/Gaucher disease
☐ Hemophilia (bleeding tendency)	☐ Urinary tract abnormalities
☐ Hydrocephalus (water on the brain)	☐ Other _____

Over ⟶

Patient name_____ Account Number_____

Environmental Exposure History

Yes No ***Since becoming pregnant*** have you...

14. Taken any prescription or over the counter medications including any of the Following:

Yes	No		Yes	No	
☐	☐	Accutane or other acne medications	☐	☐	Hormones
☐	☐	Antibiotics	☐	☐	Opioid medications
☐	☐	Anticoagulants	☐	☐	Methadone, Buprenorphine
☐	☐	Antithyroid medications			or Naltrexone
☐	☐	Barbiturates	☐	☐	Steroids
☐	☐	Birth control pills, patch or ring	☐	☐	Other_____
☐	☐	Chemotherapeutic medications			_____
☐	☐	Diet pills			_____

☐	☐	15. Had any illness or infection ?
☐	☐	16. Had fever over 101, been in a hot tub or sauna?
☐	☐	17. Had x-rays or surgery ?
☐	☐	18. Been exposed to anesthesia, lead , other heavy metals or radiation ?
☐	☐	19. Had recent exposure to pesticides or other potentially toxic chemicals?
☐	☐	20. Had any alcoholic beverages ? How many per day or week?_____
☐	☐	21. C leaned a cat litter box?
☐	☐	22. Eaten raw or very rare meat or seafood?
☐	☐	23. Smoked cigarettes? Packs/day_____ How long have you smoked?_____
☐	☐	24. Used marijuana?
☐	☐	25. Used other street drugs ? _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect or incomplete information can affect my health and/or the health of my baby. It is my responsibility to inform the provider or his/her representative of any changes in my medical status.

_____ _____ _____

Patient Signature or authorized representative Relationship of authorized rep. Date

_____ _____

Provider Signature Date