



PATIENT HISTORY
Division of Maternal Fetal Medicine & Surgery
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Name: _____ Date of Service: _____
Age: _____ Ethnic Background: _____ Language: _____
Current weight: _____ Height: _____ What was your weight before you became pregnant: _____

Date that your last period began (LMP): _____
EDC (Estimated Date of Delivery): _____
Current Gestational Age: _____
Date of first Ultrasound in this pregnancy _____

Present problem / reason for your visit (Brief):

Allergies:

Do you have allergies to any medications? YES NO If "YES," list and describe reaction:

Do you have any allergies to any food? YES NO If "YES," list:

Do you have an allergic reaction to latex? YES NO

Do you have an allergic reaction to betadine? YES NO

Obstetrical History:

Gravida:

Number of pregnancies including the present one: _____

Parity:

Number of pregnancies delivered at full term (>37 weeks): _____

Number of pregnancies delivered at pre term (<37 weeks): _____

Number of miscarriages: _____

Number of abortions: _____

Number of tubal pregnancies: _____

Number of live births: _____

Is this your first pregnancy? YES NO

If the answer is "NO," please describe **ALL** your pregnancies including miscarriages, abortions, and tubal pregnancies. Start with your first pregnancy. Do not include information about the present pregnancy.

Number 1. Date of Delivery _____ How many weeks or months at the time of delivery? _____
Newborn sex: _____ Newborn weight: _____
Hospital where delivery took place: _____
Obstetrician: _____
Type of pregnancy: NATURAL: YES NO
IVF: YES NO
CLOMID: YES NO
Complications during the pregnancy:
DIABETES: YES NO
PRE-ECLAMPSIA: YES NO
PRETERM LABOR: YES NO
Other Complications of delivery: _____
Type of delivery:
Vaginal Delivery: YES NO
Episiotomy: YES NO If "YES" then any extensions into rectum? YES NO
Labor induced: _____ or spontaneous _____
Duration of Labor _____ Type of anesthesia _____
Cesarean Section: YES NO If "YES" then indication: _____
Type of C-Section: Lower Uterine Incision Classical Uterine Incision

Number 2. Date of Delivery _____ How many weeks or months at the time of delivery? _____
Newborn sex: _____ Newborn weight: _____
Hospital where delivery took place: _____
Obstetrician: _____
Type of pregnancy: NATURAL: YES NO
IVF: YES NO
CLOMID: YES NO
Complications during the pregnancy:
DIABETES: YES NO
PRE-ECLAMPSIA: YES NO
PRETERM LABOR: YES NO
Other Complications of delivery: _____
Type of delivery:
Vaginal Delivery: YES NO
Episiotomy: YES NO If "YES" then any extensions into rectum? YES NO
Labor induced: _____ or spontaneous _____
Duration of Labor _____ Type of anesthesia _____
Cesarean Section: YES NO If "YES" then indication: _____
Type of C-Section: Lower Uterine Incision Classical Uterine Incision

Number 3. Date of Delivery _____ How many weeks or months at the time of delivery? _____
Newborn sex: _____ Newborn weight: _____
Hospital where delivery took place: _____
Obstetrician: _____
Type of pregnancy: NATURAL: YES NO
IVF: YES NO
CLOMID: YES NO
Complications during the pregnancy:
DIABETES: YES NO

PRE-ECLAMPSIA: YES NO
 PRETERM LABOR: YES NO
 Other Complications of delivery: _____
Type of delivery:
 Vaginal Delivery: YES NO
 Episiotomy: YES NO If "YES" then any extensions into rectum? YES NO
 Labor induced: _____ or spontaneous _____
 Duration of Labor _____ Type of anesthesia _____
 Cesarean Section: YES NO If "YES" then indication: _____
 Type of C-Section: Lower Uterine Incision Classical Uterine Incision

Number 4. Date of Delivery _____ How many weeks or months at the time of delivery? _____
 Newborn sex: _____ Newborn weight: _____
 Hospital where delivery took place: _____
 Obstetrician: _____
Type of pregnancy: NATURAL: YES NO
 IVF: YES NO
 CLOMID: YES NO
Complications during the pregnancy:
 DIABETES: YES NO
 PRE-ECLAMPSIA: YES NO
 PRETERM LABOR: YES NO
 Other Complications of delivery: _____
Type of delivery:
 Vaginal Delivery: YES NO
 Episiotomy: YES NO If "YES" then any extensions into rectum? YES NO
 Labor induced: _____ or spontaneous _____
 Duration of Labor _____ Type of anesthesia _____
 Cesarean Section: YES NO If "YES" then indication: _____
 Type of C-Section: Lower Uterine Incision Classical Uterine Incision

Number 5. Date of Delivery _____ How many weeks or months at the time of delivery? _____
 Newborn sex: _____ Newborn weight: _____
 Hospital where delivery took place: _____
 Obstetrician: _____
Type of pregnancy: NATURAL: YES NO
 IVF: YES NO
 CLOMID: YES NO
Complications during the pregnancy:
 DIABETES: YES NO
 PRE-ECLAMPSIA: YES NO
 PRETERM LABOR: YES NO
 Other Complications of delivery: _____
Type of delivery:
 Vaginal Delivery: YES NO
 Episiotomy: YES NO If "YES" then any extensions into rectum? YES NO
 Labor induced: _____ or spontaneous _____
 Duration of Labor _____ Type of anesthesia _____
 Cesarean Section: YES NO If "YES" then indication: _____
 Type of C-Section: Lower Uterine Incision Classical Uterine Incision

IF ANY OTHER ADDITIONAL PREGNACIES THEN PLEASE DESCRIBE ON A SEPARATE PAGE.

Medical History:

Asthma: YES NO If "YES" For how many years _____ Intubations: YES NO

Current medications _____

Diabetes: YES NO If "YES" For how many years _____ Type I _____ Type II _____

Current medications _____

Hypertension: YES NO If "YES" For how many years _____

Current medications _____

Lupus or Collagen vascular disease: YES NO

Current medications _____

DVT (clots in your legs): YES NO PE (clots in your lungs): YES NO

Have you had any of the following medical conditions?

YES	NO	CONDITION
___	___	AIDS
___	___	Anesthetic Complications
___	___	Arthritis
___	___	HAART Therapy
___	___	Bleeding disorders
___	___	Bowel disorders/colitis
___	___	Bronchitis/emphysema
___	___	Chicken Pox
___	___	Cancer /Tumors
___	___	D (Rh) Sensitized
___	___	Epilepsy (seizures)
___	___	Gallbladder/Gallstones
___	___	Glaucoma
___	___	Headaches/Migraines
___	___	Heart trouble/Heart Murmur
___	___	Hepatitis (yellow jaundice)/liver problems
___	___	Infertility
___	___	Kidney or bladder trouble, urinary tract infections
___	___	Nervous/emotional problems/depression
___	___	Rheumatic fever
___	___	Sexual abuse/rape/physical/verbal
___	___	Stomach problems/ulcers/gastritis
___	___	Stroke or paralysis
___	___	Uterine Anomaly/DES
___	___	Thyroid gland disease/goiter
___	___	Tuberculosis
___	___	Trauma/Violence
___	___	Varicosities/Phlebitis

List any other serious illnesses or injuries you have had (give dates):

Surgical History:

Tonsillectomy: YES NO

Appendectomy: YES NO

Gastric Bypass: YES NO

Gastric Banding: YES NO

Have you ever had any other surgeries/surgery? YES NO

If "YES," please give dates, reason for the operation(s) and hospital(s):

Gynecologic History:

Name of primary GYN: _____

Age at onset of menstrual cycle: _____ Days between periods _____ Duration of menstrual bleeding _____

Age at the time of first sexual relation _____ Number of partner's _____

Date of last Pap smear: Date _____ Result _____

Have you ever had abnormal pap smears: YES NO If "YES," when? _____

Did you have any treatments? YES NO If "YES" then did you have: _____

Colposcopy: YES NO If "YES" then any biopsies and results: _____

Cyrocoutery of the cervix: YES NO If "YES" then when? _____

LEEP (Loop electro excision procedure) of the cervix: YES NO If "YES" then when? _____

CONE Biopsy of the cervix: YES NO If "YES" then when? _____

Have you had any sexually transmitted disease (herpes, syphilis, Chlamydia, trichomonas, venereal warts, etc)? YES _____ NO _____ If "YES," when? _____ did you have treatment? YES _____ NO _____

Type of treatment: _____

Have you used oral contraceptives: YES NO If "YES" then Name: _____ Duration: _____

Complications with birth control pills: YES NO If "YES" please describe below: _____

Have you ever had an IUD (Intrauterine Device) placed: YES NO If "YES" then Type of IUD _____

Date of placement _____ Date of removal _____ Complications _____

Breast Disease: YES NO If "YES" then mention _____

Mammogram: YES NO If "YES" then reason and date, result: _____

Breast Ultrasound: YES NO If "YES" then reason, date, result: _____

Breast Biopsies: YES NO If "YES" the reason, date, result: _____

Vaccination History:

Seasonal Flu / H1N1 YES NO If "YES" date of last administration: _____

Tetanus YES NO If "YES" date of last administration: _____

Diphtheria YES NO If "YES" date of last administration: _____

Pertussis YES NO If "YES" date of last administration: _____

MMR YES NO If "YES" date of last administration: _____

Hepatitis B YES NO If "YES" date of last administration: _____

Hepatitis A YES NO If "YES" date of last administration: _____

HPV YES NO If "YES" date of last administration: _____

Meningococcal YES NO If "YES" date of last administration: _____

Varicella YES NO If "YES" date of last administration: _____

Medications:

List ALL medications that you use on a regular basis, including birth control pills, and non-prescriptions items such as laxatives, over the counter pain medication, cold medication, vitamins, and natural products:

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Patient, baby's father, or anyone in the family with:

YES	NO	RELATIONSHIP	
___	___	_____	Italian, Greek, Mediterranean or Oriental background
___	___	_____	Neural tube defect (open spine)
___	___	_____	Down Syndrome
___	___	_____	Jewish ancestry
___	___	_____	Sickle Cell Disease or Trait
___	___	_____	Hemophilia or other blood disorders
___	___	_____	Muscular Dystrophy
___	___	_____	Cystic Fibrosis
___	___	_____	Huntington's chorea
___	___	_____	Mental Retardation
___	___	_____	Fragile X
___	___	_____	Patient or baby's father has a child with birth defect not listed above
___	___	_____	Congenital heart defects
___	___	_____	TAY-SACHS
___	___	_____	Canavan Disease
___	___	_____	Any other hereditary Ashkenazi Jewish Disorders
___	___	_____	Familial Dysautonomia
___	___	_____	Mental Retardation / Autism
___	___	_____	Maternal Metabolic Disorders (PKU, Type I Diabetes)
___	___	_____	Recurrent pregnancy loss, or a stillbirth

Any other genetic abnormalities and/or syndromes in you, baby's father or your family: YES NO If "YES" then please list: _____

Review of systems: Have you ever had any of the following?

YES	NO	
___	___	Unexpected weight change of more than 10 lbs in the last year?
___	___	Any serious problems with you eyes or ears?
___	___	Any persistent swollen glands or unusual lumps?
___	___	Any breast lumps or nipple discharge?
___	___	Your heart frequently racing or skipping beats?
___	___	Unusual or severe shortness of breath
___	___	Frequent swelling of ankles hands or face?
___	___	Inflamed veins or clots in you veins?
___	___	Is your skin very sensitive to the sun light?
___	___	Frequent coughing or wheezing?
___	___	Serious difficulties swallowing?
___	___	Frequent or severe stomach or abdominal pain?
___	___	Frequent nausea or vomiting?
___	___	Severe constipation or diarrhea?
___	___	Blood in the stool or black stools?
___	___	Unusual skin problems or persistent sores?
___	___	Redness, severe pain or swelling of your joints?
___	___	Frequent or severe back pain?
___	___	Do you bruise easily?
___	___	Have you ever had a severe head injury?
___	___	Have you ever lost consciousness?
___	___	Have you ever broken any bones?
___	___	Have you ever had abnormal periods?
___	___	Have you ever had vaginal infections?
___	___	Have you ever had serious sexual difficulties?
___	___	Have you ever had or do you have serious problems at home or work?
___	___	Have you ever been exposed to poisons, toxins or chemicals, smoke, radioactive materials?

Social History:

Married _____ for how long? _____ Single _____ Divorced _____
Any familial relationship to partner? YES NO If "YES" then type of relation _____

Place of birth: _____ Years / months living in current Residence: _____
Town where you live: _____ Type of Residence: _____
Any pets at home? YES NO If "YES" then mention what kind _____

Occupation: _____
Years of education: _____ Level of Education: _____

Recent travel outside the United States over the last 3-4 months: YES NO If "YES" then list: _____
Recent sick contact: YES NO If "YES" then list: _____

Do you smoke? YES NO If "YES," how many cigarettes per day? _____
Do you drink? YES NO If "YES," how many drinks per week? _____
Do you use street drugs? YES NO If "YES," when was the last use? _____
What kind of drug? _____ Amount _____

What is the age of the baby's father? _____ is he involved? YES NO
Current Occupation of partner: _____
Level of education in partner: _____ Medical History _____
Genetic abnormalities in his side of the family: _____

Family History:

Has any member of your family had any of the following conditions?

CONDITION	RELATIONSHIP
Diabetes	_____
High Blood pressure	_____
Heart Disease	_____
Strokes	_____
Epilepsy	_____
Kidney disease	_____
Blood clots	_____
Toxemia of pregnancy	_____
Ovarian Cancer	_____
Colorectal Cancer	_____
Breast Cancer	_____

Any other medical conditions in your immediate family? YES NO If "YES" then please list: _____

***Do you consent to receive blood products if necessary to save your life? YES _____ NO _____**

Have you ever received a blood transfusion or blood products? YES _____ NO _____

If "YES," please give date and reason for the transfusion: _____

Please make sure that the above information is correct and thoroughly reviewed.

Patients Name: _____

Patients Signature: _____ Date: _____

