OBSTETRICAL MEDICAL HISTORY, **Patient Name**_____

Do you have any religious objections to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusion.):

_____

FAMILY HISTORY & GENETIC HISTORY

1. Have either you or the baby's father had a child born with a birth defect? ____ No ____ Yes
   If yes, please describe:_____
2. Did either you or the baby's father have a birth defect yourselves? ____ No ____ Yes
   If yes, please describe:_____
3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy, or cystic fibrosis).

   _____

   _____

   How is the affected child/person related to you?_____
4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? ___ Yes ___ No
   If yes, have either of you had genetic counseling? ____ Yes ____ No
   If yes, have either of you had chromosomal studies? ____ Yes ____ No
   Where and results:_____
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is one of these backgrounds:
   Jewish ancestry? ____ Yes ____ No If yes, have you had Tay-Sachs screening tests? ____ Yes ____ No
   Date: _____ Result: _____
   Black? ____ Yes ____ No If yes, have you had Sickle Cell screening?____ Yes ____ No
   Date: _____ Result: _____
   Mediterranean /SE Asian? ____ Yes ____ No If yes, have you had Thalassemia screening? ___ Yes ___ No
   Date: _____ Result: _____
   Caucasian? ____ Yes ____ No If yes, have you had Cystic Fibrosis screening?____ Yes ____ No
   Date: _____ Result: _____
6. Please mark if anyone in your family or the baby's father's family has:
   Diabetes ____ No ____ Yes If yes, how is that person related to you?_____
   Bleeding disorder ____ No ____ Yes If yes, how is that person related to you?_____
   Hypertension ____ No ____ Yes If yes, how is that person related to you?_____
   Cancer ____ No ____ Yes If yes, how is that person related to you?_____
7. Please list any other concerns you have about birth defects or inherited disorders:

   _____

   _____
8. Will you be 35 or older at the time the baby is born? ____ No ____ Yes
9. Will the father be 50 or older? ____ No ____ Yes

PREGNANCY HISTORY: Grav Para SAB T/EAB Stillborn Neonatal Death Other Loss Premature

No.	Date	Weeks	Sex	Wt.	Delivery Mode	Obstetrical Problems	Neonatal Problems

_____NP

EST PT__

COMPREHENSIVE WOMEN'S HEALTHCARE

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Joel A. Falk, M.D. - Eric Hazelrigg, M.D. - Susan Kudlinski, M.D.
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Patient Name: Today's Date:

Birth Date: Age: Date of Last Period:

Primary Care Physician: Referred By:

SUBJECTIVE

1. Why are we seeing you today?

2. Are you having a problem would you like evaluated today? (circle) YES NO What?

YOUR MENSTRUAL HISTORY

Age at first menses: # of days they last:

# of days in between: # of heavy days:

How often do you change a tampon or pad on your heaviest days?

Age of Menopause:

PREGNANCY HISTORY

Have you ever been pregnant (circle one) YES NO

How many times: How many children:

Complications:

YOUR MEDICAL HISTORY	YES	NO	COMMENT
Abuse			
Abnormal PAP Smear			
Breast Problems			
Ovarian Cyst			
Chlamydia, Genital Warts, HPV, GC			
HIV, Syphilis (Circle which one)			
Uterine Fibroids			
Infertility			
Endometriosis			
Vaginal Infection or Pain			
Urinary Problems			
Sexual Problems			
Painful Periods			
Heavy Periods			
Premenstrual Syndrome			
Menopausal Symptoms/Problems			
Depression and/or Anxiety			
Cancer:			
Auto Immune Condition			
Diabetes			
High BP			
High Cholesterol			
Bone Loss			
Migraines/Nuerological Problems			
Stomach/Intestinal Issues			
Thyroid Problem			
Blood Clot or Stroke			
Other:			

YOUR FAMILY HISTORY	YES	NO
Cancer:		
Blood Clots(in veins or lungs):		
Heart Disease		
Diabetes		
Stroke		
Osteoporosis		
Mental Illness		
Auto Immune Condition		
Other:		

LIST ALL SURGERIES Complications?	YES	NO

CURRENT MEDICATIONS (include over the counter and vitamins)

DRUG ALLERGIES	REACTION

SOCIAL / SEXUAL HISTORY (circle one)

Do you have sex with: Men Women Both

What Method of birth control do you and/or your partner use:

Do you smoke marijuana or use drugs? YES NO

Do you have a living will? YES NO

Have you had an HPV vaccine? YES NO

Have you had a flu shot? YES NO

Have you had the Hepatitis B Vaccine? YES NO

Do you smoke cigarettes? YES NO

Do you drink alcohol? YES NO

OFFICE USE ONLY

Year 1st seen: Date of last WWE /WT

Today's BP HT WT

Date of last PAP: Result:

Date of last Mammo: Result:

Where:

Colonoscopy NL / Abnormal Date:

BMD NL / Ostropenia / Osteoporosis Date:

Email -

Pharm #