



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been diagnosed with any of the following?

- Diabetes
- Hypertension
- Heart Disease/Murmur
- Lupus/Rheumatoid Arthritis/Sjogrens
- Kidney Disease
- Recurrent urinary tract infections/pyelo/stones
- Neurologic Disorder (ex. MS)
- Epilepsy/Seizures
- Psychiatric Disorder/Anxiety/Depression/Bipolar
- Liver Disease/Hepatitis A, B, C
- Blood Clots/DVT/Pulmonary Embolus
- Bleeding Disorder (Von Willebrands/Hemophilia)
- Hypothyroid/Hyperthyroid
- Rh Isoimmunization
- Asthma/TB
- Infertility
- Uterine anomaly
- DES exposure

Have you ever had a blood transfusion?  Yes  No Why? \_\_\_\_\_

Do you smoke?  Yes  No

How much before pregnancy? \_\_\_\_\_packs/day

How much since you found out you were pregnant? \_\_\_\_\_packs/day

Do you drink alcohol?  Yes  No

How much before pregnancy? \_\_\_\_\_drinks/week

How much since you found out you were pregnant? \_\_\_\_\_drinks/week

Do you use any drugs?  Yes  No

How much before pregnancy? \_\_\_\_\_

How much since you found out you were pregnant? \_\_\_\_\_

What drugs do you regularly use? \_\_\_\_\_

Have you ever used IV drugs?  Yes  No

Do you drink caffeine?  Yes  No \_\_\_\_\_servings/day

Do you own cats?  Yes  No Who normally cares for the litter box? \_\_\_\_\_

Do you eat fish on a regular basis?  Yes  No

Do you plan to get an epidural during labor?  Yes  No

Do you plan to have your baby circumcised if it is a male?  Yes  No

Do you plan to breast feed?  Yes  No

Are you planning on getting your tubes tied?  Yes  No

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Have you had the vaccine for hepatitis B?  Yes  No

Have you been exposed to or ever tested positive for TB (tuberculosis)?  Yes  No

Have you had the chicken pox?  Yes  No

Within the past year or since becoming pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?  Yes  No

Are you in a relationship with someone who threatens you or physically hurts you?  Yes  No

Has anyone forced you to have sexual activities that made you feel uncomfortable?  Yes  No

### **SURGICAL HISTORY**

Please list any surgeries or hospitalizations you have had in the past

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### **FAMILY HISTORY**

	<b>Age</b>	<b>Age at Death</b>	<b>Medical Problems</b>
Mom			
Dad			
Brother			
Brother			
Sister			
Sister			

Was anyone in your family or the father of the baby's family born with any birth defects?

Thalassemia:  Yes  No

Spina Bifida/Anencephaly:  Yes  No

Congenital Heart Defect:  Yes  No

Down Syndrome:  Yes  No

Tay-Sachs:  Yes  No

Sickle Cell Disease/Trait:  Yes  No

Hemophilia:  Yes  No

Muscular Dystrophy:  Yes  No

Cystic Fibrosis:  Yes  No

Huntington's Chorea:  Yes  No

