

MEDICAL HISTORY

Date of Initial Hx _____ EDD _____ LMP _____ Blood Type & Factor _____

Mother _____ Age _____ Birth Date _____ Occupation _____

Biological Father _____ Age _____ Birth Date _____ Occupation _____

Address _____ Phone Work _____ Home _____

Have you had any prenatal care? _____ With whom? _____ Do you plan to breastfeed? _____

Medical Illnesses:

Indicate if you have been diagnosed in the past by a physician with any of the following medical illnesses. List any pertinent details in the space below:

I have had none of the medical illnesses listed below to my knowledge.

_____ Heart Disease _____ Diabetes _____ Non-Surgical Hospital Stay
_____ Rheumatic Fever _____ Thyroid Problem _____ Chronic Lung Disease
_____ Varicosities _____ Liver Disease _____ Mitral Valve Prolapse
_____ Clots in Veins _____ Blood Disorders _____ High Blood Pressure
_____ Anemia _____ Pulmonary Embolism _____ Disease of Colon/Bowel
_____ Hepatitis _____ Kidney Infection _____ Neuromuscular Syndrome
_____ Blood Transfusion _____ Lupus/Rheumatoid _____ Substance Abuse/Addiction
_____ Seizures _____ Kidney Failure _____ Physical Abuse/Neglect
_____ Cancer _____ Psychiatric Illness _____ Major Injuries/Accidents
_____ Asthma _____ Chronic Allergies _____ Frequent Bladder Infections

• SURGICAL HISTORY

Indicate if you have had one or more of the following operations or procedures:

I have never had a surgery or operation to the best of my knowledge.

_____ Removal of the Right Ovary	_____ Laparoscopy
_____ Removal of the Left Ovary	_____ Hernia Repair
_____ Removal of Left Ovary Cyst	_____ D+C (Miscarriage)
_____ Removal of Right Ovary Cyst	_____ D+C (Bleeding)
_____ Removal of Left Fallopian Tube	_____ Hysteroscopy
_____ Removal of Right Fallopian Tube	_____ Stomach Stapling
_____ Tubes Tied (Tubal Ligation)	_____ Open Heart Surgery
_____ Abdominal Hysterectomy with Ovaries	_____ Surgery of the Colon
_____ Abdominal Hysterectomy/Ovaries Left	_____ Hemorrhoids/Fistula
_____ Vaginal Hysterectomy with Ovaries	_____ Breast Biopsy
_____ Vaginal Hysterectomy/Ovaries Left	_____ Surgery for Breast Cancer
_____ Appendix Removed	_____ Thyroid Surgery
_____ Bladder Repair	_____ Gallbladder Removed

List any other surgical procedure that is not specified above:

List any surgical complication you may have had in the past:

• **ALLERGIES**

Note any of the following medications or substances that cause an allergic reaction:

- I am not allergic to any medications or other substances.
- | | | | | |
|-----------------|-----------------|------------------|-------------------|----------------------|
| ___ Keflex | ___ Stadol | ___ Aspirin | ___ Sulfa Drugs | ___ Cipro |
| ___ Penicillin | ___ Hydrocodone | ___ Tetracycline | ___ Shellfish | ___ Codeine |
| ___ Amoxicillin | ___ Demerol | ___ Erythromycin | ___ Food Products | ___ Tylenol |
| ___ Ampicillin | ___ Morphine | ___ Ibuprofen | ___ Latex | <u>Other:</u> |
| ___ Macrodantin | ___ Iodine | ___ Betadine | ___ Cipro | |

MEDICATIONS:

If you are taking any type of medications, herbs, natural products, please list below:

Name of Med	Dose	Times a Day	Prescribing Dr.	Reason

I am not currently taking any medications.

PSYCHOSOCIAL

- ___ Yes ___ No Do you smoke cigarettes? If yes, amount-> ___ Packs per _____
- ___ Yes ___ No Do you drink alcohol? If yes, amount-> ___ Drinks per _____
- ___ Yes ___ No Have you ever been treated for alcohol or drug addiction?
- ___ Yes ___ No Do you consider that anyone in your household has an alcohol or other addiction problem?
- ___ Yes ___ No Are you employed full-time (>30 hours per week)?
- ___ Yes ___ No Have you changed jobs within the past 12 months or considering a job change soon?
- ___ Yes ___ No Do you use computers/radiation at home or at work?
- ___ Yes ___ No Get regular exercise?
- ___ Yes ___ No Use chemicals or harmful substances at work or home?
- ___ Yes ___ No Have religious beliefs that affect your health care?
- ___ Yes ___ No Drink caffeinated/sugared beverages?
- ___ Yes ___ No Have pets?
- ___ Yes ___ No Consume a special type of diet (veg, macrobiotic, other)?
- ___ Yes ___ No Have you ever been raped or molested?
- ___ Yes ___ No Was there domestic violence in your family growing up?
- ___ Yes ___ No Do you experience domestic violence in your current living situation?
- Can you answer yes to any of the above for your partner/birth father also?
-

Please list a few of your hobbies or interests outside the home or work:

FAMILY MEDICAL HISTORY

Indicate if any family members have been diagnosed with one or more of the illnesses listed. For this purpose, limit "family members" to include only your mother, father, sister(s), brother(s), children, and grandparents. If you have been adopted, only indicate what you know about your natural family. Do not include relatives by marriage. In the space to the side, give brief details of the particular member of the family who suffers or has died from the indicated illness. If deceased, list the approximate age of death:

Heart Attack Stroke Autoimmune Disorder (i.e. Lupus)
 Diabetes Asthma Cancer of the Ovary
 Anemias Alcoholism Cancer of the Colon
 Seizures Depression Cancer of the Breast
 High Blood Pressure Thyroid Disorders
 Blood Clotting Disorder Neuromuscular Disorders
 Neural Tube Defects Muscular Dystrophy
 Sickle Cell Disease Congenital Heart Disease
 Down's Syndrome Mental Retardation
 Hemophilia Cystic Fibrosis
 Tay-Sachs Disease Other Birth Defects
 Thalassemias Tuberculosis
 Congenital Heart Disease OTHER (Specify:)

GYNECOLOGICAL HISTORY:

Years Old What was the approximate age when your menstrual periods began?
 Yes No Have you ever had an abnormal Pap Smear?
 Laser If yes, did you have a Laser, Freezing, or other treatment performed,
 Freezing or was it simply repeated?
 Other
 Repeated
 Yes No If you have had an abnormal Pap Smear, has it occurred more than once?
 Yes No Have you ever been sexually abused, raped, or otherwise molested?
 Yes No Have you had difficulties with abnormal dark hair growths on the face, chest, or abdomen?
 Yes No Have you ever had milky discharge from the breasts and not been pregnant or immediately postpartum?

Have you been diagnosed with any of the following gynecological diseases or infections in the past:

Endometriosis "PID" Pelvic Inflammatory Disease
 Fibroids Adhesions Infertility
 Chlamydia Herpes Simplex Trichomonas
 Condyloma Genital "Warts" Syphilis
 Fibrocystic Disease Gonorrhea
of the Breast

• REPRODUCTIVE HISTORY

Total number of Pregnancies
 Total number of times that you have been in labor or had a Cesarean Section
 Total number of times that you have been in labor or had a Cesarean Section at <9 months
 Total number of miscarriages
 Total number of Living Children

Fill in details of previous pregnancies that progressed beyond the 5th month:

Number	Delivery Date	Sex	Type of Delivery	Doctor	Hospital	Birth Wt.	Type of Anesthesia

Indicate if you have had any of the following complications of pregnancy:

High Blood Pressure Diabetes RH Negative Blood Anemia
 Baby went to ICU Poor Growth Difficult Delivery Excess Wt Gain
 Excess vomiting Seizures Placenta Separated Heavy Bleeding
 Water Broke too Early Preeclampsia (+) Beta Strep Birth Defect

OTHER(Please be specific):

Has the birth father or current partner had or been exposed to any sexually transmitted diseases?

Father's blood type? _____