

Patient History

Name _____

Date _____

Do you have a history of: (If yes, please describe)

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Kidney disease/UTI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Nervous & Mental	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hepatitis/Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Varicosities/Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Major Accidents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hx of Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rh Sensitized	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Allergies (Drugs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gyne Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hospitalizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Anesthetic Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hx Of Abnormal Pap	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Uterine Anomaly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
DES Exposure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Use of Cigarettes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Use of Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Use of Street Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Current Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Infection Screening

Yes/No. If yes, please explain.

High Risk AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
High Risk Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Live with someone with TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Self/Partner with history of genital herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rash or viral illness since last menstrual period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of STD (GC, Chlamydia, HPV, Syphilis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**THIS SIDE
TO BE COMPLETED BY OBSTETRICAL PATIENTS ONLY**

Name _____ Birthdate _____

Date _____

Genetics Screening

(Includes Patient, Baby's Father, and anyone in either family with)

Patients over 35 yrs of age Yes No _____

Italian, Greek, Mediterranean, or Oriental Background Yes No _____

Neural Tube Defect/Spina Bifida/Anencephaly Yes No _____

Down Syndrome Yes No _____

Of Jewish Descent Yes No _____

French Canadian Descent Yes No _____

Tay Sachs Disease Yes No _____

Sickle Cell Disease or Trait Yes No _____

Hemophilia Yes No _____

Muscular Dystrophy Yes No _____

Cystic Fibrosis Yes No _____

Huntington Chorea Yes No _____

Mental Retardation Yes No _____

 If yes, was patient tested for Fragile X? Yes No _____

Other Inherited Generic or Chromosomal Disorder Yes No _____

Patient or father of baby have any children
 with any birth defects not listed above Yes No _____

Patient has a history of a stillbirth Yes No _____

Medications or street drugs used since last menstrual period _____
