



Name	Home Phone	Marital Status	Date
Street Address	Work Phone	Birthday	
City, State, Zip	Insurance Carrier/ID#/Group#/Phone#	Email Address	

What brings you to the office today?
<input type="checkbox"/> Annual Exam / Routine Care <input type="checkbox"/> Lab Work / STD Testing <input type="checkbox"/> OB Visit <input type="checkbox"/> Problem / Issue (Please describe briefly) <input type="checkbox"/> Procedure

Medications
What medications and supplements are you taking? (please list current medications and supplements)

Pharmacy
What pharmacy do you prefer? (please list address and phone number)

Vaccines	
What vaccines have you received? (please list vaccines)	Date of Vaccination (the year only is fine)

Allergies / Adverse Reactions	
Are you allergic to anything? (please list allergens)	What kind of reaction do you have? (please describe the reaction you experience to each)

Medical History					
	YES	NO		YES	NO
Abuse/Domestic Violence			Hepatitis		
Acid Reflux (GERD)			High Cholesterol		
Acne			Hypertension / High Blood Pressure		
Anemia or Blood Disorder			Infertility		
Anesthesia Complications			Kidney Disease		
Anxiety Disorder			Kidney or Bladder Problems		
Arthritis			Lung Disease		
Asthma			Osteoporosis		
Birth Defects or Inherited Disease			Ovarian Cancer		
Blood Transfusion			Past Pregnancy Complications		
Breast Cancer			Polyps		
Breast Problem			Pre-Eclampsia		
Depression			Psychiatric Illness		
Diabetes			Stroke		
Eating Disorder			Thrombophilias		
Eczema			Thyroid Problems		
Endometriosis			Varicosities		
Environmental Exposure					
Fibromyalgia			OTHER (please list other health problems)		
Genetic Disease					
GI Problems					
Headaches					
Heart Disease					
Heart Problems					

Genetic Screening and Infection History					
	YES	NO		YES	NO
Patient's Age Will Be 35 or Older at Estimated Date of Delivery			Maternal Metabolic Disorder (Type 1 Diabetes, PKU)		
Thalassemia (Italian, Greek, Mediterranean or Asian Background; MCV <80)			Patient or Baby's Father Had a Child with Birth Defects Not Listed		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			Recurrent Pregnancy Loss or a Stillbirth		
Congenital Heart Defect			Medications (including supplements, vitamins, herbs, OTC drugs, illicit/recreational drugs, alcohol)		
Down Syndrome			If yes, list agents and strength/dosage		
Tay-sachs (Jewish, Cajun, French-Canadian Background)			Any Other Genetic History		
Canavan Disease			Live with Someone with TB or Exposed to TB		
Sickle Cell Disease or Trait (African)			Patient or Partner Has History of Genital Herpes		
Hemophilia or Other Blood Disorders			Rash or Viral Illness Since Last Menstrual Period		
Muscular Dystrophy			History of STD, Gonorrhea, Chlamydia, HPV, or Syphilis		
Cystic Fibrosis			Prior GBS Infected Child		
Huntington's Chorea			Other Infection History		
Mental Retardation/Autism			History of HIV		
If yes, was person tested for fragile X?			History of hepatitis		
Other Inherited Genetic or Chromosomal Disorder					

Past Hospitalizations and Surgery	
Have you been hospitalized and / or received surgery? (please list instances)	Date of Hospitalization or Surgery (the year only is fine)

Social History			
Currently Employed	YES / NO	FOR PREGNANT WOMEN	
Occupation		Smoking Pre-pregnancy	YES / NO
Education		Alcohol Pre-pregnancy	YES / NO
Marital Status		Illicit Drugs Pre-pregnancy	YES / NO
Live Alone or With Others		Anesthesia Consult Planned	YES / NO
Number of Children		Is a blood transfusion acceptable in an emergency?	YES / NO
Exercise Level		Advance Directive	YES / NO
Diet		Sexually Active	YES / NO
General Stress Level	LOW / MEDIUM / HIGH	Birth Plan	YES / NO
Smoking Status	SMOKER / FORMER / NON-SMOKER	Live With Cats / Exposure to Cat Litter	YES / NO
Chewing Tobacco		Changes in Family / Social Situation	YES / NO
Years of Tobacco Use		Frequent Air Travel	YES / NO
Smoking – How Often?	# OF PACKS PER WEEK / DAY	Occupational Health Risks	YES / NO
Smoked Since Age		Passive Smoke Exposure	YES / NO
Alcohol Intake	YES / NO	Smoke / CO Detectors in Home	YES / NO
Alcohol – How Often?	# OF DRINKS PER WEEK / DAY	Supplements	YES / NO
Years of Alcohol Use			
Caffeine Intake	YES / NO		
Caffeine – How Much?	# OF DRINKS PER DAY		
Illicit Drugs	YES / NO		
Years of Illicit Drug Use			
Seat Belts Used Routinely	YES / NO		
Sunscreen Used Routinely	YES / NO		
Regular Self Breast Exams	YES / NO		
Sexually Active	YES / NO		
Sexual Partner(s)	MALE / FEMALE / BOTH		
Sexual Practices	ORAL / VAGINAL / ANAL		

Family History		
Has anyone in your family suffered from any of the following?	√ FOR YES	Relationship (Maternal or Paternal)
Breast Cancer		
Colon Cancer		
Diabetes		
Drinking Problem		
Genetic Disorder		
Heart Disease		
High Blood Pressure		
Osteoporosis		
Ovarian Cancer		
Stroke		
Other:		

GYN History			
Date of Last Menstrual Period			
Frequency of Menstrual Period	EVERY DAYS	LASTING DAYS	LIGHT / NORMAL / HEAVY
Last Pap Smear	NORMAL / ABNORMAL		
Last Mammogram	NORMAL / ABNORMAL		
Current Method of Contraception			

Past Pregnancy History		
Pregnancy # 1		
Date	# of Fetuses	GA Weeks
Labor Length	Birth Weight	Sex
Delivery Type	Outcome	Anesthesia
Delivery Place	Pre-Term Labor	Source
Notes		
Pregnancy # 2		
Date	# of Fetuses	GA Weeks
Labor Length	Birth Weight	Sex
Delivery Type	Outcome	Anesthesia
Delivery Place	Pre-Term Labor	Source
Notes		
Pregnancy # 3		
Date	# of Fetuses	GA Weeks
Labor Length	Birth Weight	Sex
Delivery Type	Outcome	Anesthesia
Delivery Place	Pre-Term Labor	Source
Notes		

OB History			
Number of Pregnancies	TOTAL:	FULL:	PRETERM:
	AB INDUCED:	AB SPONTANEOUS:	ECTOPICS:
	MULTIPLE:	LIVING:	

Have you had problems with any of the following within the past year?				
General <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Fevers <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Abnormal Thirst	Lungs <input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Blood Clot in the Lungs <input type="checkbox"/> Painful Breathing <input type="checkbox"/> Wheezing	Musculoskeletal <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Joint Pains <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Clot in Leg Vein	Menstrual Problems <input type="checkbox"/> Cramps/Pain <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Too Frequent Periods <input type="checkbox"/> Bleeding Between Periods <input type="checkbox"/> Missed a Period <input type="checkbox"/> Other Period Issue	Other Gynecologic Issues <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Itching/Irritation <input type="checkbox"/> Vulvar Pain <input type="checkbox"/> Vulvar lump/growth <input type="checkbox"/> Vulvar Sores
Eyes <input type="checkbox"/> Itchy, Red Eyes <input type="checkbox"/> Vision Problems	Cardiovascular <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Ankle/Hand Swelling	Neurologic <input type="checkbox"/> Frequent/Severe Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Trouble Walking <input type="checkbox"/> Fainting Spells	Pre Menstrual Problems <input type="checkbox"/> Bloating/Swelling <input type="checkbox"/> Mood Changes <input type="checkbox"/> Breast Changes <input type="checkbox"/> Headaches <input type="checkbox"/> Acne <input type="checkbox"/> Other PMS Issue	Sexual Problems <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Bleeding after Intercourse <input type="checkbox"/> Decreased Desire <input type="checkbox"/> Orgasm Problems <input type="checkbox"/> Dryness <input type="checkbox"/> Possible Exposure to STD <input type="checkbox"/> Other Sexual Issue
Ears <input type="checkbox"/> Ear Pain <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Hearing Loss	Gastrointestinal <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Hemorrhoids	Skin <input type="checkbox"/> Acne <input type="checkbox"/> Unwanted Hair Growth <input type="checkbox"/> Unusual Lump or Growth <input type="checkbox"/> Dry Skin	Menopause Issues <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats	Would you like to discuss any of the following? <input type="checkbox"/> Contraception <input type="checkbox"/> Menopause Issues <input type="checkbox"/> Pregnancy Issues <input type="checkbox"/> Self Breast Exam <input type="checkbox"/> Sexuality Issues <input type="checkbox"/> STDs <input type="checkbox"/> Other
Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds	Urinary <input type="checkbox"/> Incomplete Urination <input type="checkbox"/> Loss of Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Bloody Urine	Emotional <input type="checkbox"/> Excessive Worry <input type="checkbox"/> Depression <input type="checkbox"/> Frequent Crying <input type="checkbox"/> Serious thoughts of harming yourself or others	Breast Problems <input type="checkbox"/> Breast Pain <input type="checkbox"/> Breast Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Other Breast Issue	
Mouth <input type="checkbox"/> Sore Throat <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Dental Problems				

Signature

For Office Use						
HEIGHT:			WEIGHT:			
T:	P:		R:		B / P:	
URINALYSIS	LEUK:	NIT:	BLOOD:	PROT:	GLUC:	COLOR:
URINE PREGNANCY TEST: NEGATIVE / POSITIVE						