OBSTETRIC MEDICAL HISTORY

Patient Name ___________________________

Date _____________________________

- If you are uncomfortable answering any questions, leave them blank; You can discuss them with your doctor or nurse

PERSONAL HEALTH HISTORY

1. Are you allergic to any medication? Yes _____ No _____

If yes, please list:

2. Please mark any conditions that you have or have had in the past:

- Cancer _____
- Epilepsy _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney disease _____
- Hepatitis _____
- Blood clotting disorder (e.g., phlebitis) _____
- Von Willebrand's disease or other bleeding disorders _____
- Sexually transmitted diseases _____
- Recurrent urinary tract infections _____

Describe if needed:

3. Please indicate any surgery or hospitalization that you have had:

4. Please describe any health problems or symptoms that you are having at this time:

5. Do you or any family member have a history of problems with anesthesia? Yes _____ No _____ If yes, please describe:

6. Do you have any religious objections to any form of medical treatment (e.g., refusal of blood transfusion)? Yes _____ No _____ If yes, please describe:
EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? Yes__ No__
   If yes, how many packs per day? __________
   If former smoker, when did you quit? ________

2. Do you drink alcoholic beverages now or did you before you became pregnant? (1.5 oz 
spirits = 12 oz beer) Yes__ No__
   If yes, how often? ____________________________
   What type of drinks? _________________________

3. Please list any medication taken since your last period, including prescriptions, over 
the counter drugs, multivitamins, other supplements, and any herbal medicines:

4. Please list any illicit or recreational drugs used since your last period (eg, cocaine, 
marijuana):

5. Do you have any reason to believe you may have been exposed to AIDS (eg, a history 
of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to 
a gay or bisexual male, exposure to an intravenous drug user)? Yes__ No__

6. Are you ever exposed to chemicals or radiation (eg, X-rays)? Yes__ No__
   If yes, please describe:

7. Are you on a restricted diet? Yes__ No__
   If yes, please describe:

GYNECOLOGIC HISTORY

1. When was your last Pap test? ____________________________
   Have you ever had an abnormal Pap test? Yes__ No__
   If yes, when and how were you treated?
   What was the diagnosis?

2. Have you ever had:

   Gonorrhea__
   Chlamydia__
   Pelvic inflammatory disease__
   If yes, when, how and where were you treated?

3. Have you ever had herpes? Yes__ No__
   If yes, how often do you have outbreaks?
   Have you ever had syphilis? Yes__ No__
   If yes, how, when and where were you treated?

4. Have you ever used an IUD (intrauterine device) for contraception? Yes__ No__
   If yes, please indicate when:
   Did you have any problems with the IUD? Yes__ No__
5. Have you been treated for infertility? Yes  No  
   If yes, please describe when and treatment received:

6. Do you have any other concerns related to your past health history?

FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity?
   What is the ethnicity of the baby's father?

2. Have you or has the baby's father had a child born with a birth defect? Yes  No  
   If yes, please describe:

3. Did either you or the baby's father have a birth defect? Yes  No  
   If yes, please describe:

4. Please describe any abnormalities that have occurred in children of your family or the
   baby's father's family (e.g., mental retardation, birth defects, early infant death, deformities,
   or inherited diseases such as hemophilia, muscular dystrophy or cystic fibrosis):

   How is this child/person related to you?

5. Do you or does the baby's father have a history of pregnancy losses (miscarriages or
   stillbirths)? Yes  No  
   If yes, have either of you had genetic counseling? Yes  No  
   If yes, have either of you had chromosomal testing? Yes  No  
   Where and what were the results?

6. Some genetic problems occur more in couples with certain racial or ancestral
   backgrounds. Please check if you are, or the baby's father is, one of these backgrounds:

   Eastern European Jewish (Ashkenazi) ancestry? Yes  No  
   If yes, have you had Tay-Sachs screening tests? Yes  No  
   If yes, have you had a Canavan screening test? Yes  No  
   If yes, have you had familial dysautonomia screening? Yes  No  
   Date:  Result:

   African American? Yes  No  
   If yes, have you had sickle cell screening? Yes  No  
   Date:  Result:

   European Ancestry & Eastern European Jewish (Ashkenazi) ancestry? Yes  No  
   If yes, have you had cystic fibrosis screening? Yes  No  
   Date:  Result:

   Mediterranean ancestry or Southeast Asian ancestry? Yes  No  
   If yes, have you had screening for inherited forms of anemia such as thalassemia? 
   Yes  No  

7. Please list any other concerns you have about birth defects or inherited disorders:
8. Do you want to have a down syndrome risk assessment? Yes___ No___
9. Is the father 50 years or older? Yes___ No___

PSYCHOLOGICAL SCREENING

1. Do you have any problems (job, transportation etc.) that prevent you from keeping your health care appointments? Yes___ No___
2. Do you feel unsafe where you live? Yes___ No___
3. Are you exposed to second-hand smoke? Yes___ No___
4. In the past two months, have you used drugs or alcohol (including beer, wine & mixed drinks)? Yes___ No___
5. In the past year, have you been threatened, hit, slapped, or kicked by anyone you know? Yes___ No___
6. Has anyone forced you to perform any sexual act that you did not want to do? Yes___ No___
7. On a 1-5 scale (1 being low, 5 being high) how do you rate your stress level? _____
8. How many times have you moved in the past 12 months? _____

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Patient Signature

Print Name

Date