PATIENT NAME: _____ DATE OF BIRTH: _____/____/_____


# PATIENT HISTORY

**Today's Date**: _____

**Name of doctor/midwife/practice that referred you to us**: _____

**Why were you referred to us**:

_____
_____
_____
_____

**Are you currently pregnant?**
□ Yes (If "yes", please proceed)
□ No (If "no", please skip to Obstetric History below)

## ASSISTED REPRODUCTION

**If this pregnancy is the result of fertility treatment, please check all that apply:**
□ **Clomid** □ **IVF** (in-vitro fertilization) □ **IUI** (intrauterine insemination) □**ICSI** (intracytoplasmic sperm injection)

**Name of Infertility Specialist: _____**

**Was an egg donor used?** □ No □ Yes:
**If "yes", what was the age of the donor?** _____
**Was a sperm donor used?** □No □Yes
**If you used IVF, was the embryo:** □ Fresh □ Frozen
**How many embryos were implanted?** _____
**What was the implantation date?** _____
**Was genetic screening performed on the embryos?** □ No □Yes
If yes, what were the results?_____
_____

**Is this a surrogate pregnancy? □ No □ Yes**

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**OBSTETRIC HISTORY**

Please provide information for each of your previous pregnancies, **whether living or deceased, miscarried, or aborted**. Please start with your first pregnancy.

| # | Date of Delivery Indicate mo/yr | Weeks at delivery | Male or female | Birth Weight | Vaginal, Cesarean, forceps, vacuum, miscar. or aborted | If Cesarean Section, Why? | Hospital. If not local, please list city, state | Pregnancy or delivery complications | Problem with child's health at or since birth. | Staff only FOB |
|---|---|---|---|---|---|---|---|---|---|---|
| ***Example:*** | ***3/20*** | ***38*** | ***M*** | ***8 lb. 5 oz.*** | ***Cesarean*** | ***Did not dilate*** | ***HealthPark*** | ***Gestational Diabetes*** | ***NICU for breathing problems*** | |
| 1 | | | M/F | | | | | | | |
| 2 | | | M/F | | | | | | | |
| 3 | | | M/F | | | | | | | |
| 4 | | | M/F | | | | | | | |
| 5 | | | M/F | | | | | | | |
| 6 | | | M/F | | | | | | | |
| 7 | | | M/F | | | | | | | |
| 8 | | | M/F | | | | | | | |
| 9 | | | M/F | | | | | | | |
| 10 | | | M/F | | | | | | | |

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**OBSTETRIC HISTORY COMPLICATIONS**

If not already noted on the previous page, did you have any of the complications below for any of your pregnancies? If yes, please note which pregnancy/pregnancies you are referring to and explain:

| | | | |
|---|---|---|---|
| High blood pressure | □No | □Yes | |
| Diabetes | □No | □Yes | |
| Blood clot(s) | □No | □Yes | |
| Stillbirth | □No | □Yes | |
| Macrosomia/large baby | □No | □Yes | |
| Growth Restricted/small baby | □No | □Yes | |
| Short cervix/cerclage | □No | □Yes | |
| Low amniotic fluid (Oligohydramnios) | □No | □Yes | |
| High amniotic fluid (Polyhydramnios) | □No | □Yes | |
| Preterm labor or delivery | □No | □Yes | |
| Hospitalization during pregnancy | □No | □Yes | |
| Other | □No | □Yes | |
| Other | □No | □Yes | |

**ALLERGIES**

Do you have any medication or other allergies? □No □Yes

| **MEDICATION/OTHER** | **ALLERGIC REACTION** *(Ex: rash, difficulty breathing, swelling)* |
|---|---|
| | |
| | |
| | |
| | |
| | |

**MEDICATIONS**

List all prescriptions, vitamins, supplements, herbs, and any over the counter medications you are taking, or if pregnant, that you have taken since becoming pregnant.

| **MEDICATION** | **DOSE/FREQUENCY** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

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**GYNECOLOGIC HISTORY**

**D&C (s) □ No □ Yes Date(s):** _____
**LEEP □ No □Yes Date(s):** _____
**Cone Biopsy □ No □Yes Date(s):** _____
Chlamydia □ No □ Yes Date(s): _____
Gonorrhea □ No □ Yes Date(s): _____
Syphilis □ No □ Yes Date(s): _____
Herpes □ No □ Yes Date(s): _____

**MEDICAL HISTORY**

| CONDITION | NO | YES | YEAR DIAGNOSED | COMMENTS |
|---|---|---|---|---|
| Anemia | | | | |
| Arthritis | | | | |
| Asthma | | | | |
| Back Problems | | | | |
| Blood clots (DVT, Pulmonary Embolus) | | | | |
| Blood transfusion | | | | |
| Cancer | | | | |
| Diabetes | | | | |
| Heart problems/murmurs | | | | |
| Hepatitis or liver disease | | | | |
| High blood pressure | | | | |
| Kidney disease, recurrent UTI | | | | |
| Lupus or other autoimmune disorder (please specify) | | | | |
| Migraines, seizures or other neurologic condition | | | | |
| Ovarian mass, cyst, tumors | | | | |
| PCOS (polycystic ovarian syndrome) | | | | |
| Thyroid problems/mass/removal (please specify "hypo" or "hyper") | | | | |
| Uterine problems (fibroid/abnormal shape/other-please specify) | | | | |
| Other | | | | |
| Other | | | | |

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## SURGICAL HISTORY

Please provide information for any surgeries you have had:

| SURGERY | YEAR | COMMENTS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## PSYCHIATRIC/MENTAL HEALTH HISTORY

Do you have a past or current history of any of the conditions listed below? □No □Yes If "yes" please give details:

| CONDITION | DATE DIAGNOSED | COMMENTS |
|---|---|---|
| Anxiety | | |
| Bipolar | | |
| Depression | | |
| Postpartum Depression | | |
| Other | | |
| Other | | |

## SOCIAL HISTORY

**Marital status: □ Married □ Together with father of baby □ Single**
**Occupation: _____ Hours per week: _____Shift:**(please circle)**day/evening/night**
**Religion: _____**

**Tobacco use: □No □ Yes** *How much/how often*_____ **□Former** *When did you quit*_____
**Alcohol use: □No □ Yes** *How much/how often*_____ **□Former** *When did you quit*_____

**Street Drugs, either now or in the past: □No □Yes:** *List/name drug(s):* _____
_____
*Are you currently taking Methadone, Suboxone or Subutex?* **□No □Yes** *If "yes" is this □prescribed □off the street*
*If former when did you quit?*_____

**Are you currently or have you been in a domestic violence situation? □No □Yes** *If "yes", please explain:* **_____**
**_____**
**_____**

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**FATHER OF BABY HISTORY**

**Please provide the following information regarding the father of the baby for this pregnancy:**

**Name: _____ Age: _____**
**Occupation:_____**

**Any health problems, either from birth or chronic: _____**
**_____**
**_____**

**If father of baby has children from a previous relationship, please note if any were born with any health problems or have had any serious health problems since birth: _____**
**_____**
**_____**

**ANCESTRY**

| **PLEASE INDICATE ANCESTRY INFORMATION**<br>*(Note: If this pregnancy involves either a donor egg or donor sperm and you know this information, please enter it or otherwise leave it blank)* | |
|---|---|
| □**YOURSELF** □ **DONOR EGG** | □**FATHER OF BABY** □ **DONOR SPERM** |
| □ White | □ White |
| □ Black/African American | □ Black/African American |
| □ Hispanic | □ Hispanic |
| □ Italian/Greek/Mediterranean | □ Italian/Greek/Mediterranean |
| □ Jewish | □ Jewish |
| □ French Canadian | □ French Canadian |
| □ Cajun | □ Cajun |
| □ Asian | □ Asian |
| □ American (North/Central/South) Indian/Alaskan Native | □ American (North/Central/South) Indian/Alaskan Native |
| □ Native Hawaiian/Pacific Islander | □ Native Hawaiian/Pacific Islander |
| □ Mixed | □ Mixed |
| □ Unknown | □ Unknown |

**Are you and the father of the baby related by blood (**ex: cousins) □ **No** □ **Yes: _____**

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**GENETIC/FAMILY HISTORY**

Please note if **you, the father of the baby, children (even if from a previous relationship), mother, father, brothers, sisters, nieces, nephews, or first cousins** have any of the following. This only applies to person(s) related to you by blood. If pregnancy involved use of a donor egg or donor sperm, please indicate this information if known.

| Condition | Affected Individual(s) | Condition | Affected Individual(S) |
|---|---|---|---|
| Abdominal Wall Defect | | Huntington's Disease | |
| Autism/Fragile X | | Hydrocephalus | |
| Birth Defects | | Intellectual Disability | |
| Blindness | | Infant/Childhood Death | |
| Blood clotting disorder/Stroke | | Kidney Problems | |
| Cancer | | Muscular Dystrophy | |
| Cleft Lip/Palate | | Sickle Cell Disease/Trait | |
| Congenital Heart Defect | | Spinal Muscular Atrophy (SMA) | |
| Cystic Fibrosis | | Spina Bifida/Anencephaly | |
| Deafness | | Tay Sachs | |
| Diabetes | | Thalassemia | |
| Down Syndrome | | Thyroid Problems | |
| Dwarfism/Skeletal disorder | | Other | |
| Heart Problems | | Other | |
| Hemophilia/Bleeding problems | | Other | |

**Patient or Representative's Signature: _____ Date: ____/_____/_____**

PROVIDER NOTES

_____
_____
_____
_____
_____
_____
_____
_____