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

MATERNAL-FETAL MEDICINE
OF SOUTHWEST FLORIDA

pediatrix

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:* **_____**
_____
_____

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

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 *(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

_____
_____
_____
_____
_____
_____
_____
_____