

NAME: \_\_\_\_\_

**Medical History** Please indicate if you have ever had any of these; when:

Severe headaches	Bowel problems
Eye/vision glasses/contacts	Colitis
Ear/hearing problems	Blood in stool
Dental problems	Mitral valve prolapse
Last dental appt.	Gall bladder problems
Thyroid problems	Liver problems
Rheumatic fever	Hepatitis
Blood clotting problems	Diabetes/gestation diabetes
Anemia	Hypoglycemia
Hemorrhage	Toxemia
High blood pressure	Bladder/kidney infection
Varicose veins	Urinary surgery
Hemorrhoids	Aching joints
Tuberculosis	Pelvic/back injuries
Asthma	Seizures
Allergies	Hospitalizations
Stomach problems	Surgeries
Cancer	other

Do you have any allergies to any medications? \_\_\_\_\_

**Gynecological History**

Age at first period \_\_\_\_\_ Cycle length (number of days apart) \_\_\_\_\_ Period duration (number of days) \_\_\_\_\_ Normal? \_\_\_\_\_ Amount of flow: Light moderate heavy If irregular, describe: \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_ Have you ever had an abnormal Pap? \_\_\_\_\_ If so, when? \_\_\_\_\_ If so, what abnormality? \_\_\_\_\_

Please indicate if you have ever had any of the following: When:

Yeast	Cervicitis
Trichomonas	Cervical surgery
Gardnerella	Cervical polyp
Bacterial vaginosis	Ovarian cyst
Chlamydia	Fibroids
Gonorrhea	Endometriosis
Syphilis	Abnormal bleeding
PID	Uterine surgery
Genital sores	Breast lumps
Herpes: genital ___ oral ___	Breast surgery
Condyloma (genital warts)	Infertility
Other	Group B Strep

Are there any particular ethnic, cultural or religious preferences for your care you would like to discuss? \_\_\_\_\_

**Present Pregnancy**

Last menstrual period (1<sup>st</sup> day) \_\_\_\_\_ normal? Yes No  
 Last normal menstrual period \_\_\_\_\_  
 Suspected date of conception \_\_\_\_\_  
 Pregnancy test (date) \_\_\_\_\_ Planned pregnancy Yes No

Feelings about pregnancy \_\_\_\_\_

Father's feelings \_\_\_\_\_

Do you plan to breastfeed? Yes, experienced Yes, no experience  
 Undecided No (please circle one)

Most recent birth control used \_\_\_\_\_  
 Contraception used in the past: what, when, any problems? \_\_\_\_\_

Please indicate if you've had any of the following problems during this current pregnancy:

Nausea	Urinary complaints
Vomiting	Abdominal/pelvic pain
Fever	Vaginal bleeding/spotting
Headaches	Vaginal discharge
Dizziness	Other bleeding
Indigestion/heartburn	Varicosities
Leg cramps	Hemorrhoids
Rash	Bleeding gums
Backache	Insomnia
Swelling(edema)	Loneliness
Constipation	Depression
Diarrhea	Family/relationship issues
Other	Work problems

Please indicate if you have used or been exposed to any of the following during this pregnancy:

Tobacco	Herbs/supplements
Alcohol	Fumes/sprays/insecticides
Caffeine	x-rays
Marijuana	Ultrasound
Cocaine	Measles
Street drugs	Viruses
Prescriptions drugs	Immunizations
Non-prescription drugs	Cats
Vitamins	Other

Planned place of birth:  
 Home Hospital Other (circle one)

If home, please indicate if you have:  
 Electricity water telephone (circle)

Please use this space to add any other information you wish to give:  
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 \_\_\_\_\_  
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