Greater Elgin Family Care Center

Obstetric Medical History

Patient Name: _____ Date of Birth: _____ Date form Completed: _____

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

Personal Health History

Are you allergic to any medications? ☐ No ☐ Yes

If yes, please list: _____

_____

Please mark any condition that you have or have had in the past:

☐ Cancer	☐ HIV/AIDS	☐ Diabetes
☐ Epilepsy	☐ Thyroid disorder	☐ Eating disorder
☐ Heart disease	☐ Headaches	☐ Depression
☐ High blood pressure	☐ Arthritis or Lupus	☐ Asthma
☐ Kidney disease	☐ Frequent infections	☐ Anemia
☐ Hepatitis	☐ Bowel disease	☐ Herpes
☐ von Willebrand's disease or other bleeding disorder		☐ Sexually transmitted diseases
☐ Blood clotting disorder (e.g. phlebitis)		☐ Recurrent urinary tract infections

Describe, if needed: _____

_____

_____

Please indicate any surgery or hospitalization that you have had: _____

_____

_____

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

_____

_____

Do you or any family member have a history of problems with anesthesia? ☐ No ☐ Yes

If yes, please describe: _____

_____

Do you have any religious objections to any form of medical treatment (e.g. refusal of blood transfusion)? ☐ No ☐ Yes

If yes, please describe: _____

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Exposures Affecting Health

Do you smoke cigarettes? ☐ Never ☐ Yes ☐ Former Smoker If former smoker, when did you quit? _____
If yes, how many packs per day? _____

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

Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicine: _____
_____

Please list any illicit or recreational drugs used since your last period (e.g. cocaine, marijuana): _____
_____

Do you have any reason to believe you may have been exposed to HIV/AIDS (e.g. a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to gay or bisexual male or exposure to an intravenous drug user)? ☐ Yes ☐ No

Are you ever exposed to chemicals or radiation (e.g. X-rays)? ☐No ☐ Yes If yes, please describe: _____
_____

Are you on a restricted diet? ☐No ☐ Yes If yes, please describe: _____
_____

Gynecologic Health History

When was your last Pap test? _____ Have you ever had an abnormal Pap test? ☐ No ☐ Yes
If yes, when and how were you treated? _____
What was the diagnosis? _____

Have you ever had: (check all that apply) If yes, please indicate when, how and where you were treated:
- ☐ gonorrhea _____
- ☐ chlamydia _____
- ☐ pelvic inflammatory disease _____
- ☐ herpes _____ how often do you have outbreaks? _____
- ☐ syphilis _____

Have you ever used and IUD (intrauterine device) for contraception? ☐ No ☐ Yes, name _____
Did you have any problems with the IUD? _____

Have you been treated for infertility? ☐ No ☐ Yes If yes, please describe when and treatment received: _____
_____

Do you have any other concerns related to your past health history? ☐ No ☐ Yes
If yes, please list: _____

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Family History & Genetic Screening

What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

Have you or your baby's father had a child born with a birth defect? ☐ No ☐ Yes If yes, please describe:

_____

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

_____

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? _____

Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)? ☐ No ☐ Yes

If yes, have either of you had genetic counseling? ☐ No ☐ Yes

If yes, have either of you had chromosomal testing? ☐ No ☐ Yes

Where and when were the results? _____

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

☐ Eastern European Jewish (Ashkenazi) ancestry

Have you had Tay-Sachs screening tests? ☐ No ☐ Yes Date: _____ Result: _____

Have you had a Canavan screening test? ☐ No ☐ Yes Date: _____ Result: _____

Have you had Cystic Fibrosis screening? ☐ No ☐ Yes Date: _____ Result: _____

Have you had familial dysautonomia screening? ☐ No ☐ Yes Date: _____ Result: _____

☐ African American

Have you had sickle cell screening? ☐ No ☐ Yes Date: _____ Results: _____

☐ European ancestry and Eastern European Jewish (Ashkenazi) ancestry

Have you had Cystic Fibrosis screening? ☐ No ☐ Yes Date: _____ Result: _____

☐ Mediterranean ancestry or Southeast Asian ancestry

Have you ever had screening for inherited forms of anemia such as thalassemia? ☐ No ☐ Yes

Please list any other concerns you have about birth defects or inherited disorders: _____

_____

_____

Do you want to have a Down Syndrome risk assessment? ☐ No ☐ Yes

Is the father 50 years or older? ☐ No ☐ Yes

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Psychosocial Screening

Do you have any problems (jobs, transportation, etc.) that prevent you from keeping your health care appointments?	☐ No	☐ Yes
Do you feel unsafe where you live?	☐ No	☐ Yes
Are you exposed to second-hand smoke?	☐ No	☐ Yes
In the past two months, have you used drugs or alcohol (including beer, wine or mixed drinks)?	☐ No	☐ Yes
In the past year, have you been threatened, hit, slapped or kicked by anyone you know?	☐ No	☐ Yes
Has anyone forced you to perform any sexual act that you did not want to do?	☐ No	☐ Yes

On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High

How many times have you moved in the past 12 months? _____

Patient Name: _____
(please print)

Patient Signature: _____ Date: _____

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