GYNECOLOGY

Patient Addressograph

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

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FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE MONTH DAY YEAR		RACE	MARITAL STATUS S M W D SEP	ADDRESS			
OCCUPATION			EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)			
LANGUAGE				INSURANCE CARRIER/MEDICAID #			
HUSBAND/DOMESTIC PARTNER			PHONE	POLICY #			
FATHER OF BABY			PHONE	EMERGENCY CONTACT PHONE			
TOTAL PREG	FULL TERM	PREMATURE	AB, INDUCED	AB, SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) ☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION ☐ FINAL _____

MENSES MONTHLY ☐ YES ☐ NO PRIOR MENSES _____ DATE

FREQUENCY: Q _____ DAYS ON BCP AT CONCEPT ☐ YES ☐ NO

MENARCHE _____ (AGE ONSET) hCG + ___/___/___

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE/UTI		
6. NEUROLOGIC/EPILEPSY		
7. PSYCHIATRIC		
8. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
17. D (Rh) SENSITIZED		
18. PULMONARY (TB, ASTHMA)		
19. SEASONAL ALLERGIES		
20. DRUG/LATEX ALLERGIES/ REACTIONS		
21. BREAST		
22. GYN SURGERY		
23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
24. ANESTHETIC COMPLICATIONS		
25. HISTORY OF ABNORMAL PAP		
26. UTERINE ANOMALY/DES		
27. INFERTILITY		
28. RELEVANT FAMILY HISTORY		
29. OTHER		

COMMENTS _____

Before Pregnant:

YOUR HEIGHT_____in/cm YOUR WEIGHT_____lb/kg

Patient Addressograph

OBSTETRIC MEDICAL HISTORY

Patient Name: _____

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

1. ☐ Yes ☐ No Are you allergic to any medications?

If yes, please list: _____

2. 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 disorders		☐ Sexually transmitted diseases
☐ Blood clotting disorder (eg, phlebitis)		☐ Recurrent urinary tract infections

Describe, if needed: _____

3. Please indicate any surgery that you have had: _____

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

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

If yes, please describe: _____

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

If yes, please describe: _____

EXPOSURES AFFECTING HEALTH

1. ☐ Yes ☐ No Do you smoke cigarettes?
   If yes, how many packs per day? _____

2. ☐ Yes ☐ No Do you drink alcoholic beverages?
   If yes, how often? _____
   What type of drinks? _____

3. Please list any medications 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. ☐ Yes ☐ No 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)?

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

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

GYNECOLOGIC HEALTH HISTORY

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

2. ☐ Yes ☐ No Have you ever had gonorrhea ☐, chlamydia ☐, or pelvic inflammatory disease ☐ ?
   If yes, when, how, and where were you treated? _____

3. ☐ Yes ☐ No Have you ever had herpes?
   If yes, how often do you have outbreaks? _____
   ☐ Yes ☐ No Have you ever had syphilis?
   If yes, how, when, and where were you treated? _____

4. ☐ Yes ☐ No Have you ever used an IUD (intrauterine device) for contraception?
   If yes, please indicate when: _____
   ☐ Yes ☐ No Did you have any problem with the IUD?
   If yes, please describe: _____

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

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

FAMILY HISTORY & GENETIC SCREENING

1. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?

   If yes, please describe: _____

2. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?

   If yes, please describe: _____

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

   _____

   _____

   _____

   How is this child/person related to you? _____

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

   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? _____

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

   ☐ Yes ☐ No Eastern Europe Jewish ancestry

   If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No

   If yes, have you had a Canavan screening test? ☐ Yes ☐ No

   Date _____ Result _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell screening? ☐ Yes ☐ No

   Date _____ Result _____

   ☐ Yes ☐ No European Ancestry

   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry

   If yes, have you had screening for inherited forms of anemia such as thalassemia? ☐ Yes ☐ No

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

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

7. ☐ Yes ☐ No Will you be 35 years or older at the time the baby is born?

8. ☐ Yes ☐ No Will the father be 50 years or older?

PSYCHOSOCIAL SCREENING*	
1. ☐ Yes ☐ No	Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No	Do you feel unsafe where you live?
3. ☐ Yes ☐ No	In the past 2 months, have you used any form of tobacco?
4. ☐ Yes ☐ No	In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No	In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No	Has anyone forced you to perform any sexual act that you did not want to do?
7.	On a 1–5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
8.	How many times have you moved in the past 12 months? _____
9.	If you could change the timing of this pregnancy, would you want it ☐ Earlier ☐ Later ☐ Not at all ☐ No change

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____

Patient Signature

_____

Print Name

_____

Date