Care For Women's Medical Group

Original Date:
Dates Revised:

OBSTETRICAL PATIENTS ONLY

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

HUSBAND/DOMESTIC PARTNER
FATHER OF BABY (IF NOT THE SAME)

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
List any medical problems that other doctors have diagnosed		

PAST PREGNANCIES

Mos/Year	Weeks	Length of Labor	Birth Weight	Sex (M/F)	Type of Delivery	Place of Delivery	Complications

	PAST SURGERIES	
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

MEDICAL HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Diabetes	☐ Depression	☐ Seasonal Allergies
☐ Hypertension	☐ Hepatitis/Liver Disease	☐ Anesthesia Complications
☐ Heart Disease	☐ Varicose Veins	☐ History of Abnormal Pap
☐ Autoimmune Disorder	☐ Thyroid Dysfunction	☐ Weight Gain
☐ Kidney disease	☐ Rh Sensitized	☐ Other pain/discomfort:
☐ Epilepsy	☐ Asthma	

GENETIC SCREENING

Check if you, baby's father, or blood relative are positive for items listed below (Name Person)

☐ Age over 35 years (Who?)	☐ Canavan Disease	☐ Mental Retardation/Autism
☐ Italian/Greek/Asian Ethnicity	☐ Sickle Cell Disease	☐ Other Chromosomal Disorder
☐ Neural Tube Defects	☐ Hemophilia	☐ Recurrent pregnancy loss
☐ Congenital Heart Defects	☐ Muscular Dystrophy	☐ Maternal (diabetes/PKU)
☐ Down Syndrome	☐ Cystic Fibrosis	☐ Any other defects not listed previously
☐ Tay-Sachs	☐ Huntington's Chorea	

PERSONAL HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Genital Herpes	☐ Gonorrhea/Chlamydia	☐ Recent Viral Infection