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 or hospitalization 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 former smoker, when did you quit? _____
   If yes, how many packs per day? _____

2. ☐ Yes ☐ No 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? _____

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

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

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

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, 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? _____

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

6. 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 European Jewish (Ashkenazi) ancestry
If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No
If yes, have you had a Canavan screening test? ☐ Yes ☐ No
If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No
If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No
Date _____ Result _____

☐ Yes ☐ No African American
If yes, have you had sickle cell screening? ☐ Yes ☐ No
Date _____ Result _____

☐ Yes ☐ No European ancestry and Eastern European Jewish (Ashkenazi) 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

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

_____

_____

_____

_____

_____

_____

_____

8. ☐ Yes ☐ No Do you want to have a Down syndrome risk assessment?

9. ☐ Yes ☐ No Is the father 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	Are you exposed to second-hand smoke?
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? _____

*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