NAME _____

MEDICAL HISTORY Please indicate if you have ever had any of these; when:

- ☐ Severe headaches_____
- ☐ Eye/vision problems_____
- ☐ Ear/hearing problems
- ☐ Dental problems_____
- ☐ Thyroid problems_____
- ☐ Rheumatic fever_____
- ☐ Blood clotting problems_____
- ☐ Anemia_____
- ☐ Hemorrhage_____
- ☐ High blood pressure_____
- ☐ Varicose veins_____
- ☐ Hemorrhoids_____
- ☐ Tuberculosis_____
- ☐ Asthma_____
- ☐ Skin disorders_____
- ☐ Stomach problems_____
- ☐ Ulcers_____
- ☐ Chicken Pox_____
- ☐ Bowel problems/colitis_____
- ☐ Blood in stool_____
- ☐ Gall bladder problems_____
- ☐ Liver problems_____
- ☐ Hepatitis_____
- ☐ Diabetes_____
- ☐ Hypoglycemia_____
- ☐ Bladder infection_____
- ☐ Kidney infection_____
- ☐ Urinary surgery_____
- ☐ Urethral dilation_____
- ☐ Aching joints_____
- ☐ Pelvic/back injuries_____
- ☐ Seizures_____
- ☐ Cancer_____
- ☐ Hospitalizations_____
- ☐ Surgeries_____
- ☐ Other_____

Do you have any allergies? ☐ Yes ☐ No

Please list:_____

_____

GYNECOLOGIC HISTORY

Age at first period_____

Cycle length (days)_____

Regular? ☐ Yes ☐ No

Duration_____

When was your last Pap smear?

_____

Have you ever had an abnormal Pap? (dates)_____

Please describe_____

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

- ☐ Yeast_____
- ☐ Trichomonas_____
- ☐ Group B Strep_____
- ☐ Bacterial vaginosis_____
- ☐ Chlamydia_____
- ☐ Gonorrhea_____
- ☐ Syphilis_____
- ☐ PID/Pelvic infection_____
- ☐ Genital Sores_____
- ☐ Herpes: ☐ Genital ☐ Oral
- ☐ Condyloma (warts)_____
- ☐ Cervicitis_____
- ☐ Cervical surgery_____
- ☐ Cervical polyp_____
- ☐ Ovarian cyst_____
- ☐ Fibroids_____
- ☐ Endometriosis_____
- ☐ Abnormal bleeding_____
- ☐ Uterine surgery_____
- ☐ Breast lump(s)_____
- ☐ Breast surgery_____
- ☐ Infertility_____
- ☐ Other_____

Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you'd like to discuss?

_____

_____

_____

_____

_____

_____

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? ☐ Yes ☐ No

Suspected date of conception_____

Pregnancy test (date)_____

Planned pregnancy? ☐ Yes ☐ No

Feelings about pregnancy_____

Father's/Partner's feelings_____

Most recent birth control used_____

Contraception used in past; what, when, any problems?

_____

_____

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

- ☐ Nausea_____
- ☐ Vomiting_____
- ☐ Fever_____
- ☐ Infections_____
- ☐ Headache_____
- ☐ Dizziness_____
- ☐ Indigestion_____
- ☐ Leg cramps_____
- ☐ Rash_____
- ☐ Backache_____
- ☐ Swelling_____
- ☐ Constipation_____
- ☐ Diarrhea_____
- ☐ Urinary complaints_____
- ☐ Abdominal/pelvic pain_____
- ☐ Vaginal bleeding/spotting_____
- ☐ Vaginal discharge_____
- ☐ Bleeding gums_____
- ☐ Varicose veins_____
- ☐ Hemorrhoids_____
- ☐ Depression_____
- ☐ Loneliness_____
- ☐ Family/relationship problems
- ☐ Work problems_____
- ☐ Other _____

_____

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

- ☐ Tobacco_____
- ☐ Alcohol_____
- ☐ Caffeine_____
- ☐ Marijuana_____
- ☐ Cocaine_____
- ☐ Street drugs_____
- ☐ Other meds_____
- ☐ Non-pres. drugs_____
- ☐ Vitamins_____
- ☐ Herbs_____
- ☐ Fumes/sprays_____
- ☐ X-rays_____
- ☐ Ultrasound_____
- ☐ Measles/Viruses_____
- ☐ Travel_____
- ☐ Vaccinations_____
- ☐ Cats_____
- ☐ Other_____

Planned place of birth:

☐ Home ☐ Birth Center ☐ Hospital

If home, please indicate if you have:

☐ Water ☐ Electricity ☐ Telephone

Please use this space to add any other information regarding any of the above:

_____

_____

_____