

Pregnancy History Form

Name: _____ Date of birth: _____

This form **MUST** be completed and returned at least 3 business days prior to your Health Education appointment. Please see the office contact information above for mailing (first class postage \$0.69 as of 3/14/2014) or faxing your completed form to the office. You may also bring the form back to the office Front desk staff between the hours of 7:45am-5:30pm. *Congratulations on your pregnancy! We look forward to seeing you soon.*

Please check the appropriate answer or fill in the blank.

PATIENT DEMOGRAPHICS

- 1) What is your marital status?
 Single
 Engaged
 Married
 Separated
 Divorced
 Widowed
- 2) Please provide the name of the baby's father? _____
- 3) What is your preferred pharmacy name and location? _____
- 4) Do you have any religious beliefs that would impact your healthcare? (ex. You don't accept blood or blood products.) Yes No If yes, please describe. _____

ALLERGIES

- 1) Do you have any known food or drug allergy/sensitivity? Yes No
If yes, please list the allergy and describe your reaction to each food or drug allergy/sensitivity. _____
- 2) Do you have an allergy or sensitivity to latex? Yes No I don't know

MEDICATIONS

- 1) Do you take any medications? If so, please list any prescription medications and any over-the-counter medications/supplements and the reason you take them.

MENSTRUAL HISTORY

- 1) How many days are there between the beginning of one period to the beginning of the next?

- 2) What is the date of your last menstrual period? _____
- 3) How many days did your last period last? _____
- 4) Was your last menstrual period normal? Yes No
If no, please describe. _____

****If you had a pregnancy test at a facility other than at Wendover OB/GYN, please bring a copy of the results.**

GYNECOLOGICAL HISTORY

- 1) At what age did you start your first period? _____
- 2) When was your last Pap smear? _____
- 3) Was your last pap smear normal? Yes No
If you had an abnormal pap, please explain. _____
If you received treatment, please describe and give year of treatment.

- 4) Have you ever had any gynecologic surgery? Yes No
If yes, please describe. _____
- 5) Have you ever been diagnosed with a uterine or cervical defect? Yes No
If yes, please describe. _____
- 6) Have you ever been treated for any of the following sexually transmitted diseases?
- Chlamydia Yes No If Yes, when? _____
 - Gonorrhea Yes No If Yes, when? _____
 - Trichomonas Yes No If Yes, when? _____

PREGNANCY HISTORY

- 1) What was your normal weight before you got pregnant? _____
- 2) Have you been pregnant before? Yes No
- 3) Including this pregnancy, how many times have you been pregnant? _____
- 4) How many of your pregnancies were full-term – 37 weeks or more? _____
- 5) How many of your pregnancies were pre-term – less than 37 weeks? _____

- 6) How many of your pregnancies were spontaneous abortions – “miscarriages?” _____
- 7) How many of your pregnancies were induced abortions – “terminations?” _____
- 8) How many of your pregnancies were ectopic – a pregnancy outside the uterus? (Ectopics are commonly found in the fallopian tubes.) _____
- 9) How many children do you have living? _____
- 10) In chronological order, list your pregnancies and include the following information:
 - a) Month and year of delivery or abortion/miscarriage
 - b) Place of delivery
 - c) Infant’s sex
 - d) Infant’s birth weight
 - e) How many weeks pregnant you were when you delivered/terminated/miscarried
 - f) Hours in labor
 - g) Type of delivery (e.g. Vaginal, Cesarean section, Vacuum assisted, Forceps assisted)
 - h) Anesthesia during labor and delivery (e.g. Epidural, Spinal, General, Local)
 - i) Pregnancy complications (e.g. A lag in the baby’s growth, Anemia, Cervix opening too soon, Diabetes in pregnancy, Early rupture of membranes, Excessive blood loss, Excessive nausea/vomiting, Fetal death or birth defect, Hypertension in pregnancy, Infection in the uterus, Postpartum depression (depression after the baby is born), Preterm labor or birth, Too much or too little amniotic fluid)

No.	Month/ Year	Place of delivery	Infant Sex	Weight at birth	Weeks at delivery	Hrs in Labor	Type of delivery & Anesthesia	Complications	Child’s Name

HISTORY SINCE LAST MENSTRUAL PERIOD

- 1) Have you experienced any of the following since your last period?
 - a. Vaginal bleeding Yes No
 - b. Pain in the upper or lower abdomen Yes No
 - c. Headache or dizziness Yes No
 - d. Change in vision Yes No
 - e. Excessive nausea or vomiting Yes No
 - f. Urinary complaints Yes No
 - g. Fever Yes No
- 2) Have you had any alcohol since your last period? Yes No
If yes, how many and what types have you had? _____
- 3) Have you used any tobacco products since your last period? Yes No
If yes, what type and how often have you been using? _____
- 4) Have you taken any medications including prenatal vitamins and over-the-counter meds?
 Yes No
- 5) Have you been exposed to any of the following environmental toxins since your last period?
 - a. HIV, Cytomegalovirus (CMV), Herpes or Syphilis Yes No
 - b. Rubella (German Measles) or Varicella (Chicken Pox) Yes No
 - c. Phenylketonuria (PKU) Yes No
 - d. Encephalitis Yes No
 - e. Occupational chemicals such as heavy metals or organic solvents Yes No
 - f. Radiation or x-rays Yes No
 - g. Tuberculosis (TB) Yes No
 - h. Toxoplasmosis Yes No
 - i. Rash with a viral illness Yes No
 - j. Injury, trauma or surgery Yes No
- 6) Have you taken any street drugs such as marijuana, cocaine, heroin since your last period?
 Yes No If yes, please give the name of the drug(s) and how many times a day you have used it.

INFECTION/RISK

- 1) Do you have a cat? Yes No
- 2) Have you ever had Chicken Pox? Yes No
- 3) Have you ever been immunized for Varicella (Chicken Pox)?
 Yes No
- 4) Have you been treated for AIDS (HIV Positive)? Yes No
- 5) Have you ever been treated or immunized for Hepatitis? Yes No
If so, which type(s)? _____
- 6) When was your last Tetanus or Tdap vaccination? _____
- 7) Have you been immunized for Influenza? Yes No
If yes, when was your last injection? _____

INFANT CARE

- 1) Who do you plan to use as your Pediatrician (the doctor who will take care of the baby after being born?) _____
- 2) Do you plan to breastfeed or bottle feed? Breast Bottle Both Undecided
- 3) Do you plan to circumcise your son? Yes No

PERSONAL and FAMILY HEALTH HISTORY

If personal or immediate family history of the following conditions, please note who is affected and give details:

Cardiovascular – examples include

Heart Attack / MI (“Myocardial Infarction”)

- Self Mother Father Brother Sister Grandparent

Details: _____

Heart Disease such as blocked arteries, congestive heart failure

- Self Mother Father Brother Sister Grandparent

Details: _____

Rheumatic Fever – (an inflammatory disease associated with Group A Streptococcus infection)

- Self Mother Father Brother Sister Grandparent

Details: _____

Valve Disease such as Mitral Valve Prolapse

- Self Mother Father Brother Sister Grandparent

Details: _____

Chronic Hypertension / High Blood Pressure

- Self Mother Father Brother Sister Grandparent

Details: _____

Diseases of the Aorta – such as an aneurysm (the aorta is the largest artery that carries blood from the heart to the rest of the body)

- Self Mother Father Brother Sister Grandparent

Details: _____

Varicose Veins (Varicosities) or Blood Clots (Thrombophlebitis)

- Self Mother Father Brother Sister Grandparent

Details: _____

Pulmonary Embolism – (blockage of the main artery of the lung or one of its branches)

- Self Mother Father Brother Sister Grandparent

Details: _____

Blood Disorders such as high number of platelets, low number of white blood cells

- Self Mother Father Brother Sister Grandparent

Details: _____

Anemia (a decreased level of Red Blood Cells (RBC’s) or low hemoglobin level in the blood) or Hemoglobinopathy – any one of a group of genetic diseases caused by or associated with the presence of one of several forms of abnormal hemoglobin in the blood such as Hemoglobin C deficiency, Thalassemia (a group of hereditary anemias) and sickle cell trait or sickle cell anemia

- Self Mother Father Brother Sister Grandparent

Details: _____

Blood Transfusions

- Self Mother Father Brother Sister Grandparent

Details: _____

Pulmonary – examples include

Asthma

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Details: _____

Tuberculosis (TB)

Self Mother Father Brother Sister Grandparent

Details: _____

Chronic Obstructive Pulmonary Disease (COPD, chronic bronchitis, emphysema)

Self Mother Father Brother Sister Grandparent

Details: _____

Endocrine – examples include

Diabetes (high blood sugar)

Self Mother Father Brother Sister Grandparent

Details: _____

Thyroid Dysfunction (over or under active thyroid gland)

Self Mother Father Brother Sister Grandparent

Details: _____

Maternal PKU (mother’s inability to break down phenylalanine, an amino acid)

Self Mother Father Brother Sister Grandparent

Details: _____

Endocrinopathy (abnormal conditions of a gland such as the pituitary, pancreas or ovary that sends hormones to the blood)

Self Mother Father Brother Sister Grandparent

Details: _____

Gastrointestinal – examples include

Gastroesophageal Reflux Disease (“Reflux”)

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Details: _____

Irritable Bowel Disease

Self Mother Father Brother Sister Grandparent

Details: _____

Crohn’s Disease

Self Mother Father Brother Sister Grandparent

Details: _____

Liver – examples include

Hepatitis

Self Mother Father Brother Sister Grandparent

Details: _____

Cirrhosis

Self Mother Father Brother Sister Grandparent

Details: _____

Renal – examples include

Cystitis (bladder infection)

Self Mother Father Brother Sister Grandparent

Details: _____

Pyelonephritis (kidney infection)

Self Mother Father Brother Sister Grandparent

Details: _____

Asymptomatic Bacteriuria (presence of bacteria in the urine without symptoms)

Self Mother Father Brother Sister Grandparent

Details: _____

Chronic Renal Disease such as polycystic kidney disease, kidney stones

Self Mother Father Brother Sister Grandparent

Details: _____

Autoimmune – examples include

Rheumatoid Arthritis (a type of chronic painful joint inflammation)

- Self Mother Father Brother Sister Grandparent

Details: _____

Lupus (a chronic disorder that can affect the skin, tissues or organs)

- Self Mother Father Brother Sister Grandparent

Details: _____

Multiple Sclerosis (MS) (chronic disease of the central nervous system)

- Self Mother Father Brother Sister Grandparent

Details: _____

Sjogren’s Disease (disease of the glands that produce sweat and tears)

- Self Mother Father Brother Sister Grandparent

Details: _____

Cancer – any type

- Self Mother Father Brother Sister Grandparent

Details: _____

Neurologic – examples include

Cerebrovascular Accident such as stroke, aneurysm

- Self Mother Father Brother Sister Grandparent

Details: _____

Seizure Disorder

- Self Mother Father Brother Sister Grandparent

Details: _____

Migraine Headache

- Self Mother Father Brother Sister Grandparent

Details: _____

Degenerative Disease such as Amyotrophic Lateral Sclerosis (“ALS” or “Lou Gehrig’s Disease”), osteoarthritis

- Self Mother Father Brother Sister Grandparent

Details: _____

Psychologic – examples include

Psychiatric Disease/Mental Illness such as Depression, Schizophrenia, Bipolar Disorder

- Self Mother Father Brother Sister Grandparent

Details: _____

Physical Abuse or Neglect

- Self Mother Father Brother Sister Grandparent

Details: _____

Emotional Abuse or Neglect

- Self Mother Father Brother Sister Grandparent

Details: _____

Addiction to drugs, alcohol or nicotine

- Self Mother Father Brother Sister Grandparent

Details: _____

Major accidents or injuries (*need your personal history only)

- Self Details: _____

Surgical (need type and approximate date) (*need your personal history only)

- Self Details: _____

Anesthetic complications such as excessive nausea and vomiting, difficulty waking

- Self Details: _____

Non-surgical hospitalization such as treatment for childbirth, pneumonia, dehydration (*need your personal history only)

- Self Details: _____

Major accidents or injuries (*need your personal history only)

Self Mother Father Brother Sister Grandparent

Details: _____

Genetic – examples include

Cerebral Palsy (disorder that impairs control of movement)

Self Mother Father Brother Sister Grandparent

Details: _____

Cleft Lip/Palate (lip or roof of mouth not fully formed)

Self Mother Father Brother Sister Grandparent

Details: _____

Congenital Abnormalities (birth defects) such as being born with extra fingers/toes, poorly formed arm/leg

Self Mother Father Brother Sister Grandparent

Details: _____

Cystic Fibrosis (can cause severe lung and gastrointestinal tract disease)

Self Mother Father Brother Sister Grandparent

Details: _____

Down Syndrome (abnormality associated with an extra chromosome number 21 especially in women giving birth after age 35 years old)

Self Mother Father Brother Sister Grandparent

Details: _____

Hemophilia (defect in blood clotting)

Self Mother Father Brother Sister Grandparent

Details: _____

Huntington's Chorea (progressive brain disease)

Self Mother Father Brother Sister Grandparent

Details: _____

Mental Retardation (below average learning and thinking ability and behavior)

Self Mother Father Brother Sister Grandparent

Details: _____

Muscular Dystrophy (progressive muscle weakness and loss of muscle tissue)

Self Mother Father Brother Sister Grandparent

Details: _____

Neural Tube Defect (defect where the spine does not fully form such as spina bifida)

Self Mother Father Brother Sister Grandparent

Details: _____

Sickle Cell Disease or Trait (an abnormal change in the shape of red blood cells which can lead to sickle cell anemia)

Self Mother Father Brother Sister Grandparent

Details: _____

Tay-Sachs Disease (neurological disorder of the brain, found most frequently in descendants of Central & Eastern Jews)

Self Mother Father Brother Sister Grandparent

Details: _____

Fragile X (a chromosomal defect associated with the X chromosome, causing mental retardation)

Self Mother Father Brother Sister Grandparent

Details: _____

Thalassemia A or B (type of disorder of having decreased number of Red Blood Cells (RBC's) or low hemoglobin)

Self Mother Father Brother Sister Grandparent

Details: _____

Thank you for completing this form.