ASSOCIATES IN WOMEN'S HEALTH
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PREGNANCY HISTORY FORM

NAME:_____ DOB:_____

Please check the appropriate answers below.

PATIENT DEMOGRAPHICS:

1)What is your marital status?
__ Single
__ Married

2) Please provide the name of the baby's father: _____

3) What is your preferred pharmacy of choice: _____

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.

_____

_____

2) Do you have an allergy/sensitivity to latex? Yes _____ No _____ I don't know _____

CURRENT MEDICATIONS:

Do you take any medications? If so, please list any prescription medications and any over the counter meds/supplements and the reason you take them including prenatal vitamins.

_____

_____

_____

_____

_____

_____

MENSTRUAL HISTORY:

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

2) What is the first date of your last menstrual period? _____

3) How many days did your cycle last? _____

4) Was your last menstrual period normal? Yes _____ No _____

If no, please describe: _____

GYNECOLOGICAL HISTORY:

1) At what age did your start your menstrual cycles: _____

2) When was your last pap smear? _____ Was it normal? _____

If you have had an abnormal pap at anytime, please explain:

_____

If you received treatment, please describe and give the year of treatment.

_____

3) Have you ever had any gynecological surgery? Yes _____ No _____

If yes, please describe:

_____

4) Have you ever been diagnosed with a uterine or cervical defect? Yes _____ No _____

If yes, please describe:

_____

5) 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? _____

Herpes Yes _____ No _____ If yes, when? _____

Syphilis Yes _____ No _____ If yes, when? _____

HIV Yes _____ No _____ If yes, when? _____

PREGNANCY HISTORY

1) What was your normal weight before you became pregnant? _____
2) Have you been pregnant before? _____
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 pregnancy were spontaneous abortions "miscarriages?" _____
7) How many of your pregnancies were induced abortions-"terminations?" _____
8) How many of your pregnancies were ectopic or outside of the uterus? _____
9) How many living children do you have? _____

In chronological order, please 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 were you at the time of birth, miscarriage or termination
f) Hours in labor
g) Type of delivery (Vaginal, C-section, Vacuum assisted, Forceps assisted)
h) Anesthesia during labor and delivery (e.g. Epidural, Spinal, General, Local)
i) Pregnancy Complications (fetal growth, cervix opening too soon, diabetes, hypertension, excessive nausea/vomiting, fetal death or defect, infection in the uterus, postpartum depression, preterm labor or birth, too much or too little amniotic fluid) or any other complications you need to address.

HISTORY SINCE LAST MENSTRUAL CYCLE:

1) Have you experienced any of the following symptoms since your last period?

a. Vaginal bleeding: Yes _____ No _____

b. Unusual or severe pain in the abdomen: Yes _____ No _____

c. Excessive nausea or vomiting: Yes _____ No _____

d. Urinary complaints: 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? _____

5) Have you been exposed to any of the following since your last period?

a. Occupational chemicals such as heavy metals or solvents: Yes _____ No _____

b. Radiation or X-rays: Yes _____ No _____

c. Tuberculosis (TB): Yes _____ No _____

d. Blood products (i.e. transfusions): Yes _____ No _____

6) Have you taken any street drugs such as marijuana, cocaine, heroine or methamphetamine 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 _____ If yes, does the cat go outdoors? Y ___ or N ____

2) Have you ever had Chicken Pox? Yes _____ No _____

3) Have you even been immunized for Varicella (Chicken Pox)? Yes _____ No _____

4) Have you ever been treated for AIDS (HIV positive)? Yes _____ No _____

5) Have you ever been treated or immunized for Hepatitis? Yes _____ No _____

If so, what 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? _____

8) Have you had any illnesses since your last period? Yes _____ No _____

If yes, what were they? _____

_____

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 Strep 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

__Self __Mother __Father __Brother __Sister __Grandparent

Details: _____

Varicose Veins 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 or Hemoglobinopathy -any one of a group of genetic diseases caused 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: _____

PULMONARY-EXAMPLES INCLUDE:

Asthma

__Self __Mother __Father __Brother __Sister __Grandparent

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

__Self __Mother __Father __Brother __Sister __Grandparent

Details: _____

GASTROINTESTINAL-EXAMPLES INCLUDE:

Gastroesophageal Reflux Disease (GERD or Reflux)

__Self __Mother __Father __Brother __Sister __Grandparent

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 infections)

__Self __Mother __Father __Brother __Sister __Grandparent

Details: _____

Pyelonepheritis (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 or kidney stones

__Self __Mother __Father __Brother __Sister __Grandparent

AUTOIMMUNE-EXAMPLES INCLUDE:

Rheumatoid Arthritis (a type of 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: _____

NEUROLOGICAL-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 Headaches

__Self __Mother __Father __Brother __Sister __Grandparent

Details: _____

Degenerative Disease such as ALS or Lou Gehrig's Disease, Osteoarthritis

__Self __Mother __ Father __ Brother __Sister __ Grandparent

Details: _____

PSYCHOLOGICAL-EXAMPLES INCLUDE:

Psychiatric Disease/Mental Illness such as Depression, Schizophrenia, or 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 AND TYPE AND APPROXIMATE DATE 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, ETC

__Self: Details: _____

GENETIC-EXAMPLES INCLUDE:

Cerebral Palsy (disorder that impairs or control 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 etc.

__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)

__Self __Mother __Father __Brother __Sister __Grandparent

Details: _____

Hemophilia (blood clotting defect)

__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)

__Self __Mother __Father __Brother __Sister __Grandparent

Details:_____

Tay-Sachs Disease (neurological disorder of the brain, found most frequently in Jewish descendants

__Self __Mother __Father __Brother __Sister __Grandparent

Details: _____

Fragile X (a chromosome 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

Thank you for completing this form.