**Desert West Obstetrics and Gynecology**
**Confidential Obstetrical History**

Name _____ Birth Date _____ Age_____ Date _____

| **Current Medications** (Prescription, over the counter, herbal) | **Prescribing Doctor** | **Dose** | **Instructions** | **Reason Used** |
|---|---|---|---|---|
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| **Allergies to medications/food/environment** | **Reaction** |
|---|---|
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## Gynecologic Health History

LMP (first day of your last period): _____

___ Definite
___ Unknown date
___ Approximate date

Were your periods regular before pregnancy? No____ Yes____

How often did your cycles occur? _____-(# of days from start of one cycle to start of next cycle)

Were you on Birth Control at time of conception? No___ Yes___
If yes, what type of Birth Control were you using? _____

What age were you when you started your first period? _____

Have you had a positive pregnancy test? No___ Yes___

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If yes, when and where was the test done? _____

Was this a planned pregnancy? No ____ Yes ____

Was this pregnancy a result of In vitro fertilization? No____ Yes____

If yes, donor sperm? No ____ Yes ____

If yes, donor egg? No ____ Yes ____

If yes, what was date of conception? _____

### *Total number of pregnancies*

| Full Term | Premature | Cesarean Section | Vaginal Delivery | Living | Multiple births | Abortion | Miscarriage | Ectopic |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**Have you had a positive Group B Strep status with any pregnancies? No _____ Yes____ Unsure____**

### *Pregnancy Details*

| Preg # | Sex | Month/ Year of delivery | Number of weeks | Babies Weight | Hrs of Labor | Delivery Type | OB/Neonatal Problems | Delivery Doctor |
|---|---|---|---|---|---|---|---|---|
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Name _____ Birth Date _____ Age_____ Date _____

Symptoms since your last period?

_____

_____

What medications have you taken since your last period?

_____

_____

## Medical History

**Have you had or have any of the following conditions:**

| Disease/Condition | Yes | No | Onset date | Treatment |
|---|---|---|---|---|
| 1. Diabetes | | | | |
| 2. Hypertension | | | | |
| 3. Heart Disease | | | | |
| 4. Autoimmune Disorder | | | | |
| 5. Kidney Disease/UTI | | | | |
| 6. Neurologic/Epilepsy | | | | |
| 7. Psychiatric | | | | |
| 8. Depression/Postpartum Depression | | | | |
| 9. Hepatitis/liver disease | | | | |
| 10. Varicosities/phlebitis/ blood clot | | | | |
| 11. Thyroid Dysfunction | | | | |
| 12. Trauma/Violence | | | | |
| 13. History of blood Transfusions | | | | |

| | Pre Pregnancy | During Pregnancy | # years use |
|---|---|---|---|
| 14. Tobacco(Packs per day) | | | |
| 15. Alcohol (Amt. per day) | | | |
| 16. Illicit/Recreational Drugs (Amt daily, weekly, etc) | | | |

| Disease/Condition | Yes | No | Onset date | Treatment |
|---|---|---|---|---|
| 17. Rh sensitized | | | | |
| 18. Pulmonary (TB, Asthma) | | | | |
| 19. Seasonal allergies | | | | |
| 20. Drug/latex allergies/ | | | | |

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| | | | | |
|---|---|---|---|---|
| reactions | | | | |
| 21. Breast problems | | | | |
| 22. GYN surgery | | | | |
| 23. Operations/Hospitalization | | | | |
| 24. Anesthetic complications | | | | |
| 25. History abnormal pap | | | | |
| 26. Uterine anomaly/DES | | | | |
| 27. Infertility | | | | |
| 28. ART Treatment | | | | |
| 29. Relevant family history | | | | |
| 30. Received HPV vaccine | | | | |

**(We do recommend that you discontinue use of nicotine, alcohol, caffeine, and recreational drugs)**

## Infection History

| | Yes | No | Onset Date | Treatment |
|---|---|---|---|---|
| 1. Exposed to/live with someone with TB | | | | |
| 2. Patient/Partner with History genital Herpes | | | | |
| 3. Rash/viral Illness since Last period | | | | |
| 4. Hepatitis B or C | | | | |
| 5. **History of:** | | | | |
| STD | | | | |
| Gonorrhea | | | | |
| Chlamydia | | | | |
| HPV/Warts | | | | |
| HIV | | | | |
| Syphilis | | | | |
| 6. Have you had Chicken pox | | | | |

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## Medical / Surgical History *(Include injuries and conditions requiring medications i.e.-high blood pressure, diabetes, seizures, etc)*

| Condition/Disease | Date | Treatment |
|---|---|---|
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If medically necessary, would you agree to a transfusion? No_____ Yes_____

Do you desire sterilization after pregnancy? No ___ Yes ___

Will you be breast feeding? No ____ Yes___
Will you be bottle feeding? No ____ Yes ___
Will you be breast and bottle feeding? No ___ Yes ___

## *Family History*

Please complete if any of your close relatives have had any of the following:

| Disease | Circle Yes/No | Family Member | Family Members 1st Name | Age of Onset | Age of Death | Cause of Death (Circle) |
|---|---|---|---|---|---|---|
| Cancer of Breast | Yes No | | | | | Yes No |
| Cancer of Ovary | Yes No | | | | | Yes No |
| Cancer of Uterus | Yes No | | | | | Yes No |
| Cancer of Cervix | Yes No | | | | | Yes No |
| Cancer of Colon | Yes No | | | | | Yes No |
| Diabetes | Yes No | | | | | Yes No |
| Tuberculosis (TB) | Yes No | | | | | Yes No |
| Heart Disease | Yes No | | | | | Yes No |
| High Blood Pressure | Yes No | | | | | Yes No |
| Blood clot/PE | Yes No | | | | | Yes No |
| Other: | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |

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## Social History

Primary LanguageSpoken_____Race_____

Education_____ Degree Obtained_____

Baby's father _____ Baby's father race _____

Support person for pregnancy _____

Pediatrician _____

Do you smoke? No_____ Yes_____ If yes, type of tobacco?_____ Pks/day_____ Number of years_____
If yes, amount during pregnancy? _____
Second hand smoke exposure? No _____ Yes _____

Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol _____
How often? _____ Amount _____Last drink_____
If yes, amount during pregnancy? _____

Do you consume caffeine? No_____ Yes_____ If yes, amount daily? _____ Type _____

Do you use recreational drugs? No_____ Yes____ If yes, what type? _____ Amount _____
If yes, amount during pregnancy? _____

**(We do recommend that you discontinue use of nicotine, alcohol, caffeine, and recreational drugs)**

Exercise frequency? Daily_____ Never_____ Occasional_____ 2-3times/wk_____ 4 or more times/wk_____

Are there animals in the home? No_____ Yes_____ If yes, what kind? _____

Is the patient the individual who cleans up after the animals? No_____ Yes_____

Do you have smoke detectors in your home? No____ Yes____

How many sexual partners do you have? None_____ One_____ 2-5_____ 5+_____

Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____
If yes, please explain _____

_____

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## Genetic History
**(Includes patient, baby's father, or anyone in either family)**

| | Yes | No | Mother(patient) | Father(baby's) | Other relative and relationship |
|---|---|---|---|---|---|
| 1. Patient's age 35 or older at delivery | | | | | |
| 2. Thalassemia | | | | | |
| 3. Neural tube defect | | | | | |
| 4. Congenital heart defect | | | | | |
| 5. Down syndrome | | | | | |
| 6. Tay-sachs | | | | | |
| 7. Canavan disease | | | | | |
| 8. Familial dysautonomia | | | | | |
| 9. Sickle cell disease or trait | | | | | |
| 10. Hemophilia or other Blood disorders | | | | | |
| 11. Muscular dystrophy | | | | | |
| 12. Cystic fibrosis | | | | | |
| 13. Huntington's chorea | | | | | |
| 14. Mental retardation/ Autism | | | | | |
| 15. Other inherited genetic or chromosomal disorder | | | | | |
| 16. Metabolic Disorder ( e.g. PKU, Type 1 Diabetes) | | | | | |
| 17. Patient or baby's father had a child with birth defects not listed above | | | | | |
| 18. Recurrent pregnancy loss or stillbirth | | | | | |
| 19. Other | | | | | |