

# OBSTETRICAL PATIENT MEDICAL HISTORY

DATE:	NAME:	DATE OF BIRTH:	AGE:
FATHER OF BABY/PARTNER:		1 <sup>ST</sup> DAY OF LAST PERIOD:	RACE:

## FAMILY HISTORY

HAS ANYONE IN EITHER YOUR FAMILY OR THE BABY'S FATHER'S FAMILY HAD:

	YES	NO	IF YES, WHO?
THALASSEMIA			
NEURAL TUBE DEFECT			
HEART DEFECT			
DOWN SYNDROME			
TAY-SACHS			
CANAVAN DISEASE			
SICKLE CELL DISEASE OR TRAIT			
HEMOPHILIA			
MUSCULAR DYSTROPHY			
CYSTIC FIBROSIS			
HUNTINGTON'S CHOREA			
MENTAL RETARDATION			
AUTISM			
OTHER INHERITED DISORDER			
RECURRENT PREGNANCY LOSS OR STILLBIRTH			

## PERSONAL HISTORY

	YES	NO
HAVE YOU HAD PREGNANCY LOSSES OR STILLBIRTHS?		
DO YOU HAVE DIABETES?		
DO YOU OR THE BABY'S FATHER HAVE A BIRTH DEFECT?		
HAVE YOU OR THE BABY'S FATHER HAD A CHILD WITH A BIRTH DEFECT?		
HAVE YOU TAKEN ANY NEW MEDICATIONS SINCE YOUR LAST MENSTRUAL PERIOD? IF YES, WHAT?		

## INFECTION / ENVIRONMENTAL EXPOSURE

	YES	NO
HAVE YOU HAD A RASH OR FEVER SINCE YOUR BECOMING PREGNANT?		
DO YOU OR YOUR PARTNER HAVE GENITAL HERPES?		
DO YOU HAVE CONTACT WITH ANYONE WITH TUBERCULOSIS?		
DO YOU HAVE A HISTORY OF A SEXUALLY TRANSMITTED INFECTION?		
HAVE YOU HAD CHICKENPOX?		
ARE YOU EXPOSED TO LEAD, CHEMICALS OR RADIATION?		

## INFECTION / ENVIRONMENTAL EXPOSURE CONTINUED

	YES	NO
ARE YOU EXPOSED TO PEOPLE WITH INFECTIONS AT WORK?		
ARE YOUR VACCINATIONS UP TO DATE?		
ARE THERE CATS IN YOUR HOME?		
OTHER:		
PROVIDER COMMENTS:		