

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

No	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY	PROVIDER NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

GESTATIONAL DIABETES HYPERTENSION/HIGH BLOOD PRESSURE PREECLAMPSIA/TOXEMIA
 OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? NO YES HOW WAS IT TREATED?

CURRENT MEDICATIONS

(INCLUDING HORMONES, VITAMINS, HERBS, AND NON-PRESCRIPTION MEDICATIONS)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

SOCIAL HISTORY

	YES	NO	PROVIDER NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:			
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINKS:			
DRUG USE			
SEAT BELT USE			
REGULAR EXERCISE: HOW LONG & HOW OFTEN?			
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS DAILY INTAKE:			
HEALTH HAZARDS AT HOME OR WORK?			
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?			

PERSONAL PROFILE

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL

MARITAL STATUS: MARRIED LIVING WITH PARTNER SINGLE WIDOWED DIVORCED

NUMBER OF LIVING CHILDREN: _____

NUMBER OF PEOPLE IN HOUSEHOLD: _____

SCHOOL COMPLETED: HIGH SCHOOL SOME COLLEGE/AA DEGREE COLLEGE GRADUATE DEGREE OTHER

CURRENT OR MOST RECENT JOB: _____

TRAVEL OUTSIDE THE UNITED STATES: _____ LOCATIONS: _____

FAMILY HISTORY

MOTHER: LIVING DECEASED/CAUSE AGE: _____ FATHER: LIVING DECEASED/CAUSE AGE: _____

SIBLINGS: NUMBER LIVING: _____ NUMBER DECEASED: _____ CAUSE(S)/AGE(S) _____

CHILDREN: NUMBER LIVING: _____ NUMBER DECEASED: _____ CAUSE(S)/AGE(S) _____

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PROVIDER NOTES
DIABETES	___		
STROKE	___		
HEART DISEASE	___		
BLOOD CLOTS IN LUNGS/LEGS	___		
HIGH BLOOD PRESSURE	___		
HIGH CHOLESTEROL	___		
OSTEOPOROSIS	___		
HEPATITIS	___		
HIV/AIDS	___		
TUBERCULOSIS	___		
BIRTH DEFECTS	___		
ALCOHOL/DRUG PROBLEMS	___		
BREAST CANCER	___		
COLON CANCER	___		
OVARIAN CANCER	___		
UTERINE CANCER	___		
MENTAL ILLNESS/DEPRESSION	___		
ALZHEIMER'S DISEASE	___		

PERSONAL PAST HISTORY OF ILLNESS

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PROVIDER NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
FIBROIDS				
SEXUALLY TRANSMITTED INFECTIONS				
INFERTILITY				
HIV/AIDS				
HEART ATTACK / HEART DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
AUTOIMMUNE DISEASE				
CHICKENPOX				
CANCER, TYPE:				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION / ANXIETY / MENTAL ILLNESS				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE				
LIVER DISEASE				
THYROID DISEASE				
HEADACHES				
INFERTILITY				
BLEEDING DISORDERS				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

HEALTH CARE MAINTENANCE

	DATE		DATE
LAST MAMMOGRAM		LAST COLONOSCOPY	
LAST CHOLESTEROL/LIPIDS PROFILE		LAST TSH	
LAST BONE DENSITY TEST		DO YOU HAVE A PRIMARY CARE DOCTOR? NAME:	

IMMUNIZATIONS/TESTS

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES/MUMPS/RUBELLA (MMR) VACCINE		TUBERCULOSIS SKIN TEST RESULT:	