Name________________________________ Date of Visit____________________________

What brings you into the office today?____

____

First day of last period:____/____/____ Are you currently pregnant? **Y or N**

Menstrual and Sexual History	
Age when you first started periods?	How many days between periods now?
How many days does your period last?	Is your flow? Light Moderate Heavy
Do you have pain with periods? None Mild Moderate Severe	
Have you ever been sexually assaulted? **Y or N**	Are you in an unsafe relationship right now? **Y or N**
Have you ever had? None Gonorrhea Chlamydia Trichinosis Genital Warts Syphilis Herpes	
Have you ever had HPV or an abnormal Pap smear? **Y or N** Date of last Pap Smear____/____/____	
Allergies	
Are you allergic to latex? **Y or N**	Are you allergic to betadine? **Y or N**

Please list any drug allergies and reactions:______________________________________

____

Medications

Please list all medications and dosages:____

____

____

ESTABLISHED patients with no obstetric history changes may check here and skip Obstetric History section ☐

Obstetric History

DOB	Weeks Pregnant	Vaginal or C-Section	Weight	Sex	Name	Any Problems

Number of miscarriages: Number of abortions: Number of ectopics:

ESTABLISHED patients with no medical history changes may check here and skip Medical and Surgical History section ☐

Medical History and Surgical History

Anesthetic complications	Y or N	Hypertension	Y or N
Autoimmune Disorder	Y or N	Kidney Disease	Y or N
Breast Problems	Y or N	Liver Disease	Y or N
D (Rh) Sensitized	Y or N	Neurologic/Epilepsy	Y or N
Depression/Post-Partum	Y or N	Psychiatric Diagnosis	Y or N
Diabetes	Y or N	Asthma, TB, COPD	Y or N
Drug/Latex Allergies	Y or N	Seasonal Allergies	Y or N
Hepatitis	Y or N	Uterine Anomaly	Y or N
History of Abnormal Pap	Y or N	UTI	Y or N
History of Blood Transfusion	Y or N		

Other medical history:____

____

Surgeries:____

____

Social History

Do you smoke or Vape? **Currently** **In the Past** **Never** If so, how much per day?_________

If so, for how many years?_______ Quit Date?____________

Have you used smokeless tobacco? **Currently** **In the Past** **Never** Quit Date?____________

List any recreational drugs:____

Do you drink alcohol? **Currently** **In the Past** **Never** How many drinks per week?_________

In an average month, how many times do you have 6 or more drinks at once?_______________

Are you sexually active? **Yes** **Not Currently** **Never**

How do you prevent pregnancy?____

Are your partners? **Male** **Female**

Have you been exposed to TB? **Y** **or** **N**

Have you had a rash or viral illness since your last menstual period? **Y** **or** **N**

Do you or your partner have a history of genital herpes? **Self** **Partner** **Neither**

ESTABLISHED patients with no family history changes may check here and skip Family History section ☐

Family History

Please list any medical problems in your family members:

Mother____

Father____

Sister____

Brother____

Daughter____

Son____

Maternal Grandmother____

Maternal Grandfather____

Paternal Grandmother____

Paternal Grandfather____

Other Relative (Please specify)____

____

Other

Do you have little interest or pleasure in doing things?

Not at all **Several days** **More than half the days** **Nearly every day**

Do you feel down, depressed, or hopeless?

Not at all **Several days** **More than half the days** **Nearly every day**

Date of last mammogram (if 40 years or older) ____/____/____

Date of last colonoscopy or Cologuard (if 45 years or older) ____/____/____

Do you desire STI testing today? **Y** **or** **N** (Per State requirements, this will be done today if you are pregnant.)

Preferred Pharmacy Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

Current Problems					
Constitutional	Yes	No	**Genitourinary**	Yes	No
Activity Change			Difficulty Urinating		
Appetite Change			Painful Sex		
Chills			Painful Urination		
Fatigue			Leaking Urine		
Fever			Frequent Urination		
Unexpected Weight Change			Genital Sores		
Eyes			Blood in Urine		
Discharge			Menstrual Problem		
Itching			Pelvic Pain		
Visual Disturbance			Urinary Urgency		
Endocrine			Vaginal Bleeding		
Cold Intolerance			Vaginal Discharge		
Heat Intolerance			Vaginal Pain		
Excessive Urination			**Neurological**		
Allergy/Immunology			Dizziness		
Environmental Allergies			Headaches		
Food Allergies			Numbness		
Immunocompromised			Seizures		
HENT			Fainting		
Congestion			**Hematologic**		
Ear Pain			Swollen Lymph Nodes		
Hearing Loss			Easy Bruising or Bleeding		
Mouth Sores			**Gastrointestinal**		
Nose Bleeds			Abdominal Bloating		
Runny Nose			Abdominal Pain		
Sinus Pain			Anal Bleeding		
Sinus Pressure			Constipation		
Sneezing			Diarrhea		
Sore Throat			Nausea		
Trouble Swallowing			Vomiting		
Respiratory			**Musculoskeletal**		
Chest Tightness			Joint Pain		
Cough			Back Pain		
Shortness of Breath			Problems Walking		
Wheezing			Joint Swelling		
Cardio			Muscle Pain		
Chest Pain			**Psychiatric**		
Leg Swelling			Easily Agitated		
Palpitations			Depressed Mood		
Skin			Nervous/Anxious		
Rash			Self Injury		
Wound			Suicidal Thoughts		

Genetic Screening Questionnaire

Will you be 35 or older when you deliver? **Y or N**

Is the father of the baby 40 or older? **Y or N**

Do you or the father of your baby have a known personal or family history of any of the following?

	Yes	No
Thalassemia		
Neural Tube Defect (Meningomyelocele, spina bifica, or anencephaly)		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs		
Canavan Disease		
Sickle Cell Disease or Trait		
Hemophilia/Blood Disorder		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Mental Retardation/Autism		
Fragile X Syndrome		
Other Genetic or Chromosomal Disorder		
Type 1 Diabetes		
PKU		
Other Birth Defect		
Recurrent Pregnancy Loss/Stillbirth		

List any medications, supplements, vitamins, herbs, or OTC medications taken during pregnancy:

____

____

____

____

____

____

____