PATIENT MEDICAL INFORMATION SHEET

Name _____

Age _____

Please answer these questions honestly so we can help you receive the best possible care for you and your baby. Ask the nurse for help if you have difficulty with these questions. **Your answers will become a confidential part of your medical record.** Thank you for completing this assessment.

Have you had an ultrasound examination during this pregnancy? ☐ No ☐ Yes
If Yes, When and where was the ultrasound done?_____

ALLERGIES

Are you allergic to any medicines?	☐ No	☐ Yes	If yes what medicines?
Are you allergic to Latex?	☐ No	☐ Yes	
Are you allergic to iodine?	☐ No	☐ Yes	

CURRENT MEDICATIONS

Name	Dosage/frequency	Reason	Dates medication taken

Physician's comments: _____
_____
_____

OBSTETRICAL HISTORY
What was the first day of your last menstrual period (LMP)? _____
Have you ever been told that you had one of the following while pregnant? (Please check all that apply)
☐ Diabetes ☐ High blood pressure ☐ Preeclampsia ☐ Incompetent cervix
Physician's comments: _____
_____
_____

All Pregnancies
Please list all pregnancies (including miscarriages and abortions) in chronological order.

Year	vaginal	cesarean	D&C	Birth Weight	Weeks at delivery	Complications	Physician's comments
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				
	☐	☐	☐				

_____ _____
Patient Signature Date

PATIENT MEDICAL INFORMATION SHEET

Name _____

MEDICAL HISTORY: Have you been told that you have one of the following conditions? (Check all that apply)

	Specify (if appropriate)	Year of onset of condition	Medication taken (dose & frequency)	Dates medication taken	Physician's comments
☐ High blood pressure					
☐ Heart problems					
☐ Kidney problem (such as infection, stones, or cysts)					
☐ Lung problems (except asthma)					
☐ Liver problems (such as hepatitis or gallstones)					
☐ Intestinal problems					
☐ Thyroid problems					
☐ Seizures (epilepsy)					
☐ Diabetes					
☐ Lupus					
☐ Tuberculosis					
☐ Cancer					
☐ Asthma					
☐ Blood disorder (such as sickle cell, thalassemia,)					
☐ Blood clots					
☐ Low platelets					
☐ Genital Herpes					
☐ HIV					
☐ Psychiatric disorder (Depression, anxiety, bipolar disorder,etc)					

_____ _____

Patient Signature Date

PATIENT MEDICAL INFORMATION SHEET

Name _____

SURGICAL HISTORY

Have you had any operations? (Including LEEP, cone biopsy, or cerclage)	☐ No	☐ Yes	If yes what type and when?	Physician's comments

Transfusion History (Please check all that apply)

	When and why	**Physician's comments**
☐Prior blood transfusion		
☐ Any of your children require a blood transfusion?		

EXPOSURES: Have you been exposed to any of the following during this pregnancy? (Please check all that apply)

	What type	**Date of exposure**	**Physician's comments**
☐ X rays			
☐ Chemicals			
☐ High fever			

FAMILY HISTORY: Is there any history of birth defects such as heart defects, extra fingers or toes , mental retardation, chromosomal disorder, cystic fibrosis, Tay-Sachs, Canavan disease, learning problems, autism, blindness deafness, bone or skeletal disorder, nerve or muscular disorder, cystic kidney, etc.

In your family?	☐ No	☐ Yes	If yes please describe the defect.
In the baby's father's family?	☐ No	☐ Yes	If yes please describe the defect.
Has any one in your family had blood clots	☐ No	☐ Yes	If yes how old was the family member when they had the clot?
Has any one in your family had a stroke?	☐ No	☐ Yes	If yes how old was the family member when the stroke occurred?

HABITS- Please check all that apply

				Last use?
Have you ever smoked cigarettes	☐ No	☐ Yes	If yes how many cigarettes per day?	
Do you drink alcohol?	☐ No	☐ Yes	If yes how many drinks per day?	
Have you ever used drugs that were not prescribed? (such as PCP, marijuana, cocaine, heroin, speed	☐ No	☐ Yes	If yes, what drugs?	

Has anyone hit you or physically abused you in the last year?	☐ No	☐ Yes	If yes who and when?

_____ _____

Patient Signature Date