CORNERSTONE
WOMEN'S CARE

Obstetrical Patient Health and Family History – Page 1

Patient Name *(First, Last)* _____

Today's Date _____ **Birth Date** _____

Allergies

❍ Yes ❍ No *Details* _____

_____

Personal Health History – Major Illnesses

❍ Arthritis	❍ Depression	❍ Emotional Disorders
❍ Asthma	❍ Group B Strep	❍ High Blood Pressure
❍ Epilepsy	❍ Bowel Trouble	❍ Blood Disease
❍ HIV	❍ Fibromyalgia	❍ Bladder Infection
❍ Migraines	❍ Bleeding Disorder	❍ Chicken Pox
❍ Cancer	❍ Heart Problems	❍ Bowel Disease
❍ Herpes	❍ Kidney Disease	❍ Skin Disorders
❍ Lupus	❍ Diabetes	❍ Thyroid Disorder
❍ Hepatitis	❍ Hyperactivity/ADD	❍ Other

_____

List Any Surgery/Operations in the Past

_____

_____

_____

Current Health Issues and Symptoms

_____

_____

_____

Family Genetic History – Some genetic problems occur more frequently with certain racial or ancestral backgrounds. Do either you or baby's father have one of these backgrounds:

Jewish ❍ Yes ❍ No African American ❍ Yes ❍ No

If you answered Yes, have you had the following:

Tay-Sachs Screening ❍ Yes ❍ No

Sickle Cell Screening ❍ Yes ❍ No

Results _____

Exposures Affecting Health

Tobacco ❍ Yes ❍ No *Quantity*_____

Details _____

Alcohol ❍ Yes ❍ No *Quantity*_____

Details _____

Illegal Drug Use ❍ Yes ❍ No *Quantity*_____

Details _____

Cat Owner ❍ Yes ❍ No *Quantity*_____

Details _____

Exposed to AIDS ❍ Yes ❍ No

Details _____

Flu Vaccine ❍ Yes ❍ No

Details _____

Chemical Exposure ❍ Yes ❍ No

Details _____

Special Diet ❍ Yes ❍ No

Details _____

Obstetrical Medical History

Objections to any form of medical treatment ❍ Yes ❍ No
(Example: Blood Transfusion)

Details _____

Hearing/Audio Needs ❍ Yes ❍ No

Details _____

Vision Needs ❍ Yes ❍ No

Details _____

Language Needs ❍ Yes ❍ No

Details _____

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Family Genetic History

	Yes	Specify Relative(s)
You/Father of Baby (FOB) have a child with birth defects?	❍	
Details		
Do You have birth defects?	❍	
Details		
Does FOB have birth defects?	❍	
Details		
Does Your family/FOB's family have a history of birth defects?	❍	
Details		
Does Your family/FOB's family have a history of inherited diseases?	❍	
Details		

Family Genetic History – Pregnancy Losses

You— ❍ Miscarriage ❍ Stillborn
❍ Genetic Counseling ❍ Chromosomal Studies

Details _____

Father of the baby— ❍ Miscarriage ❍ Stillborn
❍ Genetic Counseling ❍ Chromosomal Studies

Details _____

Gynecological Health History

	Yes	Date
Last Menstrual Period	❍	
Details		
Last Pap Smear	❍	
Details		
Abnormal Pap Smear	❍	
Details		
STDs: Chlamydia, Gonorrhea, Pelvic Inflammatory Disease or other Sexual Transmitted Disease	❍	
Details		
Contracted Herpes	❍	
Details		

Gynecological Health Cont.

	Yes	Date
Receive HPV Vaccine	❍	
Details		
Bladder/Kidney Infection	❍	
Details		
Use Contraceptives	❍	
Details		
History of Infertility	❍	
Details		

Family Genetic History – Baby's Mother/Father Disorders

Diabetes	❍ Yes	❍ No
Details		
Bleeding Disorder	❍ Yes	❍ No
Details		
High Blood Pressure	❍ Yes	❍ No
Details		
Cancer	❍ Yes	❍ No
Details		
Hepatitis	❍ Yes	❍ No
Details		
HIV	❍ Yes	❍ No
Details		
Twins/Multiple Births	❍ Yes	❍ No
Details		

List Any Concerns About Birth Defects or Inherited Disorders

_____

_____

Personal Profile

Will You Be 35+ at Baby's Birth? ❍ Yes ❍ No

Will Father Be 50+ at Baby's Birth? ❍ Yes ❍ No

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