The Women's Medical Clinic
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Today's Date:_____

FOR ALL NEW OBSTETRICAL PATIENTS

Name:_____Date of Birth:_____
Age:____Occupation:_____ Are you Married?_____
Husband/ Partner (father of Child):_____
His age:_____ His Occupation:_____
Was this pregnancy planned?:_____

MENSTRUAL HISTORY

When was the first day of your last menstral period?:_____
When was the period previous to that?:_____
Do you normally have regular monthly periods?:_____
If you have ever been on birth control pills, when was the last time that you were on them?:_____
Have you had any bleeding since your last period?:_____
Cramping?:_____
How much did you weigh at your last menstral period?:_____

OBSTETRICAL HISTORY

Please list all pregnancies that went beyond 6 months:

Date of Delivery	Full term or premature	Vaginal or Cesarean	Weight	Sex	Current health of child

Were any of the pregnancies complicated by:

- ☐ Postpartum hemorrhage or difficulty removing placenta.
- ☐ Prolonged labor or difficult delivery.
- ☐ Heavy bleeding.
- ☐ Serious infection (during or after).
- ☐ Premature labor.
- ☐ Toxemia (high blood pressure).

☐ Postpartum depression

Other complications:_____

Did you breast-feed?_____ For how long?_____

Do all of your children have the same father?_____

Please list all abortions:

Date	How many weeks?	Complications?

Please list all miscarriages:

Date	How many weeks?	D & C	Complications?

Have you ever had a tubal pregnancy?_____

A molar pregnancy?_____

GYNECOLOGICAL HISTORY

Have you had an abnormal Pap smear?_____

When was your last pap smear?_____

Please check any of the following that you have ever had:

☐ Yeast infection
☐ Herpes
☐ Syphilis
☐ Trichomonas
☐ Chlamydia
☐ Genital warts
☐ Pelvic Inflammatory disease
☐ Gonorrhea

Have you had difficulty getting pregnant?_____

PAST GENERAL HEALTH

Please check any of the following that you have ever had:

- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ Blood clots
- ☐ Asthma
- ☐ Stomach problems
- ☐ Emotional problems
- ☐ Kidney infection or kidney disease
- ☐ Hepatitis
- ☐ Heart disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Anemia
- ☐ German measles
- ☐ Eating disorders
- ☐ Typhoid fever
- ☐ Tuberculosis
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Seizures
- ☐ Migraines
- ☐ Alcohol / drug abuse
- ☐ Chicken pox

Please list any other health problem not listed:_____

_____

Have you ever been hospitalized for anything other than a delivery or an operation?_____

Please list all operations that you have had:

Date:	Type of Surgery	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications that you are currently taking: _____

_____

_____

Are you allergic to any medications?_____

If yes, please list _____

_____

Have you ever had problems with excessive bleeding (for example, at the dentist) or easy bruising?: _____

Have you ever had a blood transfusion?_____

Do you smoke?:_____ How long have you smoked?:_____

When you are not pregnant, how many alcoholic drinks do you have

(on average) each week?:_____
Have you been exposed to any toxic agents (fumes) or taken any medications so far?:_____

FAMILY MEDICAL HISTORY

Please list any disease that runs in your family (particularly diabetes, heart disease, high blood pressure):_____
_____

Please list the age and health of the following people:

Mother_____ Father _____
Sister_____ Brothers_____
_____ _____
_____ _____

Does anyone in your family or the father of the baby's family have a congenital malformation, mental retardation or a chromosomal abnormality (such as Down's syndrome) ?_____

Or any of the following diseases:

- ☐ Tay Sachs disease
- ☐ Cystic fibrosis
- ☐ Duchenne Muscular Dystrophy
- ☐ Phenylketonuria
- ☐ Niemann-Pick disease

Are you or your husband Jewish?:_____
Of Mediterranean origin?:_____
What is your race or ethnicity?:_____
Do twins run in the family?:_____

AFTER DELIVERY

Do you plan to breast-feed?:_____
If you have a son, will you want him circumcised?:_____
If you do not want more children, will you want a tubal ligation?:_____