PATIENT HISTORY FORM

LAST NAME	FIRST	AGE	RACE	OCCUPATION
MARITAL STATUS	EDUCATION		OCCUPATION	
BABY'S FATHER'S NAME		AGE	OCCUPATION	EDUCATION

REVIEW OF SYSTEMS (Circle positive symptoms and describe and/or add others, if needed)

Constitutional: Unexplained fever, abnormal weight loss or gain, fatigue

Eyes: Double vision, blurring, vision changes

ENT/Mouth: Hearing loss, ear infections (other than childhood), sinus problems, mouth sores, dental problems

Cardiovascular: Chest pain, palpitations, irregular/rapid heartbeat, unexplained fainting, swelling of legs

Respiratory: Chronic cough, spitting up blood, shortness of breath, wheezing

Gastrointestinal: Abdominal pain, nausea/vomiting, frequent diarrhea, bloody stool, constipation

Genitourinary: Blood in urine, pain with urination, abnormal periods, painful intercourse

Musculoskeletal: muscle weakness, arthritis or joint pain/deformity

Skin/breast: Breast masses, pain, discharge

Neurological: Seizures, loss of balance/coordination, paralysis, weakness, loss of memory

Psychiatric: Depression, anxiety, hallucinations, sleep disturbances, crying frequently

Endocrine: Excessive thirst, excessive urination, heat/cold intolerance, abnormal dry skin

Hematologic/Lymphatic: frequent bruising, cuts do not stop bleeding, enlarged lymph nodes

Allergic/Immunologic: Hives, eczema, itching, allergies

Other: _____

_____

MEDICAL AND FAMILY HISTORY

Please check if you or any blood relative (parents, siblings, children, grandparents, aunts, uncles) have any of the following:
Circle any conditions you are unsure of.

SELF	FAMILY	CONDITION	SELF	FAMILY	CONDITION
_____	_____	cancer	_____	_____	high blood pressure
_____	_____	heart/valve disease	_____	_____	rheumatic fever
_____	_____	lung disease	_____	_____	stomach/bowel problems
_____	_____	kidney disease	_____	_____	urinary problems/infections/malformation
_____	_____	diabetes	_____	_____	anemia/blood disorder
_____	_____	other endocrine/hormone disorder	_____	_____	mental disorder/depression
_____	_____	seizures/convulsions/epilepsy	_____	_____	abnormal babies
_____	_____	genetic disease	_____	_____	twins/triplets
_____	_____	infertility	_____	_____	strokes/blood clots/varicose veins

Does the baby's father or his family have any history of abnormal babies or genetic disorder? _____ No _____ yes

Please check if you have had any of the following:

_____ Blood transfusion
_____ Infectious disease
_____ Hepatitis
_____ Tuberculosis
_____ PKU
_____ Abnormal Pap smear
Date of last Pap smear: _____

_____ Sexually transmitted disease
_____ Genital herpes
_____ Genital warts, HPV
_____ Chlamydia
_____ Gonorrhea
_____ Syphilis
_____ History of group B strep infection

HABITS/ENVIRONMENT

No	Yes			
☐	☐	cigarettes-now	_____ per day	_____ years
☐	☐	cigarettes-ever	_____ per day	_____ years
☐	☐	alcoholic drinks	_____ per day	_____ per week
☐	☐	Do you or have you ever used street drugs? (*marijuana, cocaine, crack, uppers, downers*)		

OBSTETRICAL HISTORY

Date last menstrual period started: _____ Are you sure of this date? _____

When was your pregnancy test positive? _____

Allergies to any medications: _____

Please list any medications you have taken since your last menstrual period: _____

_____

Please list any medication you are taking now: _____

_____

Which pregnancy is this for you (include miscarriages, terminations, ectopics) _____

Please list how many of each of the following you have had:

_____ Vaginal delivery _____ C-section _____ Miscarriage _____ Termination _____ Ectopic (tubal)

Please complete the following for each pregnancy:

#	Date	Type of Delivery	Length of Labor	Weeks Gestation	Male or Female	Baby's Weight	Complications

Please list any surgeries you have had:

Approximate Date:	Surgery:

PLEASE LIST ANY OTHER INFORMATION WE MAY NEED TO PROVIDE YOU WITH QUALITY OBSTETRICAL CARE:

_____ _____ _____ _____

PATIENT SIGNATURE DATE PHYSICIAN SIGNATURE DATE

Subsequent Visits:

Physician Initials:	Date reviewed: