Women's Health of Oregon

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CONFIDENTIAL MEDICAL HISTORY FOR PREGNANT PATIENTS

Name:_____ DOB:_____ Today's Date:_____

Preferred Name:_____ Primary Care Provider:_____

MENSTRUAL HISTORY

When was the first day of your last period?_____How sure are you about this date? SURE/UNSURE

Was this a planned pregnancy?_____

Have you seen another provider or been to the ER or urgent care since you knew you were pregnant?_____

If yes, where:_____

OBSTETRICAL HISTORY

How many pregnancies have you had? (**including this one**)_____

How many living children do you have? _____

How many of your deliveries were full term? (after 37 weeks)_____ before 37 weeks_____

How many C-sections have you had?_____ Vaginal deliveries?_____

How many elective abortions have you had? _____ Miscarriages? _____

How many ectopic/tubal pregnancies have you had?_____

Any sets of multiples? (Twins, Triplets, etc.)_____

Have you had any complications during past pregnancies? () Breech () Bleeding () Premature Labor

() High Blood Pressure () Premature Delivery () Gestational Diabetes () NONE

Other:_____

Have you ever had any problems becoming pregnant? () NO () YES

Delivery Date	**# weeks gestation**	**Type of delivery**	**Birth Wt.**	**Sex**	**Complications**

MEDICATIONS Please list all medications you are currently taking or have taken since you knew you were pregnant.

Medication	Dose	Prescriber

ALLERGIES

() NO KNOWN DRUG ALLERGIES

Medication Name	Reaction

GENETIC HISTORY () My family history is unknown () My baby's father's history is unknown

Please indicate if there is a history of the following:

Genetic History	*You/Your family*	*Baby's Father/Family*
Thalassemia	() NO () YES	() NO () YES
Neural Tube Defect	() NO () YES	() NO () YES
Down's Syndrome	() NO () YES	() NO () YES
Tay-Sach's or Jewish Descent	() NO () YES	() NO () YES
Sickle Cell Disease/Trait	() NO () YES	() NO () YES
Hemophilia	() NO () YES	() NO () YES
Muscular Dystrophy	() NO () YES	() NO () YES
Cystic Fibrosis	() NO () YES	() NO () YES
Huntington's Disease	() NO () YES	() NO () YES
Intellectual Disability	() NO () YES	() NO () YES
Congenital Birth Defect	() NO () YES	() NO () YES
Other Genetic/Chromosomal Abnormality	() NO () YES	() NO () YES
Child with birth defects	() NO () YES	() NO () YES
More than 3 miscarriages	() NO () YES	() NO () YES
History of stillbirth	() NO () YES	() NO () YES

SOCIAL HISTORY

Marital Status: () Single () Married () Partnered () Divorced () Separated () Widowed

Sexually active with: () Males () Females () Both

Number of sexual partners in the last _____ 1 year _____ 3 years.

Do you feel safe in your current relationship?_____

Do you feel safe at home? () YES () NO Are you currently being hit, kicked, punched, or slapped? () N () Y

Do you need to discuss violence at home with your provider? () NO () YES

Your Occupation:_____

Your Education Level: () Grade School () High School () College

Father of the baby's name:_____ Age:_____ Relationship:_____

Father of the baby's ethnicity:_____Occupation:_____

Contact Number:_____

HABITS/EXPOSURES

Do you use tobacco products? () Never () I currently do () I used to, but quit in_____

If you currently use or used tobacco products, how old were you when you started?_____

What types of tobacco products do you currently use/did you use?_____

() Cigarettes_____ # per day () Cigars () Chewing Tobacco

Are you exposed to second hand smoke? () NO () YES

Do you use alcohol? () NO () YES () Quit for pregnancy

If yes, how many drinks per week do you consume?_____ Type of alcohol?_____

Do you use illicit substances? () NO () YES if yes, what type(s) and how often._____

Do you have any of the following risk factors? () Multiple blood transfusions () Partner with HIV

() Partner with Hepatitis C () Partner with Hepatitis B

Other:_____

How many caffeinated beverages do you consume each day?_____

How many times a week do you exercise? () NONE () Active but no formal exercise () 1-3 times per week

() 4 or more times per week () Everyday

When was your last pap smear?_____ Was it normal? () YES () NO

Infectious history and dates: () Chlamydia () Gonorrhea () Herpes () Other_____

Have you had chicken pox? () YES () NO age:_____ Last TDAP (tetanus) vaccine:_____

Last flu vaccine:_____