# NEW PATIENT HISTORY FORM

LAST NAME: _____ FIRST NAME: _____ OBSTETRICIAN _____

LAST PERIOD: _____ USUAL TIME BETWEEN PERIODS: _____

IF IVF-TRANSFER DATE:_____ OCCUPATION:_____ HRS. WORKED/WK: _____

WEIGHT PRIOR TO PREGNANCY: _____ AGE: _____ HEIGHT: _____

FILL IN THE FOLLOWING INFORMATION FOR EACH OF YOUR PREVIOUS PREGNANCIES INCLUDING ANY LOSSES, MISCARRIAGES & ABORTIONS

| | MONTH/YEAR OF DELIVERY | MALE/ FEMALE | VAGINAL DELIVERY/ C-SECTION | BABY WEIGHT | WEEKS GESTATION | PROBLEMS OR COMPLICATIONS FOR YOU OR THE BABY |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

GYN HISTORY (ABNORMAL PAPS, FIBROIDS, OVARIAN CYSTS, ETC): _____

_____

PREVIOUS PROBLEMS WITH ANESTHESIA: _____

_____

OTHER COMMENTS: _____

_____

_____

PLEASE CHECK ALL THAT APPLY. IF YOU HAVE ANY QUESTIONS ABOUT AN ITEM PUT A **?** NEXT TO IT.

IN YOUR **CURRENT** PREGNANCY, HAVE YOU HAD ANY OF THE FOLLOWING:

____ HOSPITAL ADMISSION BEFORE LABOR
____ BLEEDING
____ SEVERE VOMITING
____ INCOMPETENT CERVIX
(SHORTENING OR OPENING OF CERVIX)
____ DO YOU HAVE A "STITCH" IN YOUR CERVIX
____ EARLY LABOR
____ BREAKING OF WATER
____ HIGH BLOOD PRESSURE
____ DIABETES

____ MORE THAN ONE BABY
____ REDUCTION OF A BABY #____
DID YOU LOSE ONE OF YOUR BABIES _____
____ IS YOUR BABY SMALLER THAN IT SHOULD BE
____ IS YOUR BABY LARGER THAN IT SHOULD BE
____ IS YOUR AMNIOTIC FLUID (WATER) TOO MUCH
____ IS YOUR AMNIOTIC FLUID (WATER) TO LITTLE
____ WERE YOU IN THE HOSPITAL
____ INFECTION IN YOUR FLUID (WATER)
____ DID YOU HAVE ANY INFECTIONS

## NEW PATIENT HISTORY FORM

IN YOUR **PREVIOUS** PREGNANCIES DID YOU HAVE ANY OF THE FOLLOWING:

_____ C-SECTION
_____ HOSPITAL ADMISSION
_____ BLEEDING
_____ SEVERE VOMITING
_____ PREGNANCY IN A TUBE (ECTOPIC)
_____ INCOMPETENT CERVIX (SHORTENING OR OPENING OF YOUR CERVIX)
_____ EARLY LABOR
_____ DELIVERY BEFORE 37 WEEKS
_____ EARLY BREAKING OF WATER
_____ HIGH BLOOD PRESSURE
_____ DIABETES
_____ INFECTION IN THE AMNIOTIC FLUID (WATER)
_____ RH PROBLEMS OR JAUNDICE IN THE BABY
_____ DEPRESSION AFTER DELIVERY
_____ SMALL BABY AT BIRTH
_____ LOSS OF BABY AFTER 24 WEEKS
_____ ABNORMAL BABY
_____ BABY IN THE NEONATAL INTENSIVE CARE UNIT

GENERAL HISTORY:

ALLERGIES: _____

MEDICATIONS: _____

TOBACCO USE PER DAY: NONE ____ <10____ 10-12____ >20____

ALCOHOL USE PER DAY: NONE ____ SOCIAL ____ DAILY____ ALCOHOLISM/BINGE DRINKING ____

DRUG USE: NONE ____ USE DRUGS TYPE_____

OPERATIONS/HOSPITALIZATIONS: _____
_____

HAVE YOU EVER HAD:

____TRANSFUSION
____HIGH BLOOD PRESSURE
____LUNG DISEASE OR ASTHMA
____STOMACH/BOWEL PROBLEMS
____EMOTIONAL/PSYCHIATRIC PROBLEMS
____BONE/SPINE PROBLEMS
____DISEASE/URINE INFECTIONS
____VAGINAL INFECTIONS
____ HIV
____BLOOD CLOTS/CLOTTING DISORDER
____DIABETES
____HEART DISEASE
____ANEMIA
____SEIZURE DISORDER
____HERPES
____WARTS/HPV
____CANCER
____BLEEDING TENDENCIES
____THYROID DISEASE
____LIVER DISEASE
____AUTOIMMUNE DISEASE/LUPUS
____ABNORMAL UTERUS/FIBROIDS
____KIDNEY DISEASE/URINE INFECTIONS
____ABNORMAL PAP
____HURT IN AN ACCIDENT

## NEW PATIENT HISTORY FORM

FAMILY HISTORY:

ETHNICITY

_____CAUCASIAN
_____AFRICAN AMERICAN
_____MEDITERRANEAN
_____ASIAN
_____JEWISH
_____HISPANIC

ETHNICITY/SPOUSE

_____CAUCASIAN
_____AFRICAN AMERICA
_____MEDITERRANEAN
_____ASIAN
_____JEWISH
_____HISPANIC

ARE YOU RELATED TO YOUR HUSBAND? _____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING PROBLEMS:

_____HIGH BLOOD PRESSURE
_____DIABETES
_____CYSTIC FIBROSIS
_____CONGENITAL HEART DISEASE
_____ANEMIA
_____STROKE
_____CHROMOSOME PROBLEM
_____CLOTTING PROBLEMS
_____BIRTH DEFECTS

TYPE OF DEFECTS _____

_____CLEFT LIP/PALATE
_____OPEN SPINE DEFECT
_____MENTAL RETARDATION
_____DOWNS SYNDROME
_____SEIZURES
_____MENTAL ILLNESS
_____INHERITED GENETIC DISEASE
_____BLEEDING DISORDER

COMMENTS:

_____

_____

_____

_____

_____