OB COMPREHENSIVE MEDICAL HISTORY **Name** ______________________ **Date** ________

Medical History

Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date
Anemia				Infertility			
Anesthesia complications				Kidney problem/disease (specify)			
Anorexia				Kidney infection			
Arthritis				Liver problem/disease (specify)			
Asthma				Lung problem/disease (specify)			
Autoimmune disease				Major Accident			
Birth defects				Measles			
Bladder infection				Migraines			
Blood disorders/disease (specify)				Mitral Valve Prolapse			
Blood transfusion				Mono			
Cancer (specify)				Ovarian cysts/growths			
Chickenpox				Infection of uterus/tubes/ovaries			
Chlamydia				Psychiatric disorder (specify)			
Depression				Rheumatic fever			
Deep Vein Thrombosis				Syphilis			
Diabetes				Thyroid problems/disease (specify)			
Epilepsy				Tuberculosis			
Gastrointestinal problem/disease				Varicose Veins			
Genital herpes				Abnormal Pap smear			
Genital warts				Uterine growths/fibroids			
Gonorrhea				Uterine/Cervical Abnormality			
Hay fever/seasonal allergies							
Heart problem/disease (specify)				**Indicate whether you've had these tests and date of last one**			
Hepatitis (specify type)				Pap smear			
High blood pressure				Mammogram			
HIV				Thyroid testing			

Your family doctor: ______________________ **Pediatrican:** ______________________

Surgical History

Date	List all previous hospitalizations, surgeries and procedures

Are you adopted? No Yes **If yes, do you know your family history? No Yes**

Family Medical History

Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)	Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)
Asthma				Hay fever/allergies			
Birth Defect				Heart disease (specify)			
Blood disorder				Hepatitis (specify type)			
Cancer (specify)				High blood pressure			
Deep Vein Thrombosis				Liver disease			
Diabetes				Kidney disease (specify)			
Gastrointestinal disease				Psychiatric disease			
Goiter				Thyroid disease			
				Tuberculosis			

Social History

Highest Level of Education

Grade school _____ years
High school _____ years
College _____ years
Postgraduate _____ years

Substance Use

	Never	Usual amount used before pregnancy	Amount used since known to be pregnant
Caffeine			
Tobacco			
Alcohol			
Street drugs			

Marital Status (circle please)

Single Married
Engaged Divorced

Sexual History

More than 1 partner last 12 mos? **YES NO**
More than 3 partners in lifetime? **YES NO**

Any history of sexual abuse? **YES NO**
Any history of physical abuse? **YES NO**

Religion ______________ **Occupation** ______________

Genetic History

Have you, your partner, your blood relatives or his blood relatives ever had:			
	NO	YES	List family member
Cerebral palsy			
Congenital birth defects			
Cystic fibrosis			
Down syndrome			
Mental retardation			
Neural tube defect			
Sickle cell disease			
Twins			
Triplets			
Are you and your partner blood relatives?			

Please state your ethnic background:	Your partner's ethnic background:	
Father of your baby:	Relationship:	Is this your first child together? **YES NO**
How old is the father of your baby?		

Pregnancy History **Have you ever been pregnant? No Yes Please list all pregnancies:**

Delivery Date	Mo. Along	Vag or C-section	Complications	Living

Have you ever had a miscarriage or abortion? Yes No

Date	Wks. Along	Miscarriage	Abortion	Complications

Menstrual History

First day of your last period ______________ Are you certain? **YES NO** Did you have a normal flow? **YES NO**

How often do you have periods? Every ________ days

How long do they last? __________days

Typical flow: Light Mod Heavy

Age at very first period: ________

Last contraceptive used: ______________________

When? ________________

Current Pregnancy History

In *this* pregnancy have you had:	NO	YES	If yes, please give details
Headaches			How often?
Dizziness			
Nausea			
Vomiting			How often?
Vaginal discharge			When?
Vaginal spotting or bleeding			When?
Urinary complaints			
Swelling of feet, ankles, hands or face			
Fever			How high? When?
Cold or the flu			When?
Rash			Where? When?
Exposure to x-ray			When?
Exposure to communicable disease			What disease? When?
Non-prescription drugs			List all:
Prescription drugs			List all:
What did you weigh at the time you got pregnant?			

List all current medications	
List all medication allergies	