**For items you have checked "YES," please specify the type problem, date, and treatment received.**

**Last menstrual period** _____

| PRIOR MEDICAL HISTORY | YES | NO | (Include date and type of treatment) |
|---|---|---|---|
| Diabetes | | | |
| Bladder Infections | | | |
| Kidney Problems | | | |
| Heart Problems | | | |
| Rheumatic Fever | | | |
| High Blood Pressure | | | |
| Herpes (genital) | | | |
| Vaginal Infections | | | |
| Female Organ Problems* | | | |
| Abnormal Pap Smear* | | | |
| Chicken Pox | | | |
| German Measles or vaccine | | | |
| Red Measles or vaccine | | | |
| Mumps or vaccine | | | |
| Epilepsy (seizures) | | | |
| Sensitive to drugs (specify) | | | |
| Allergies | | | |
| Blood Transfusions | | | |
| Anemia (low blood) | | | |
| Bleeds Easily | | | |
| Infertility | | | |
| Migraines | | | |
| Thyroid Problems | | | |
| Nervous / Mental Problems | | | |
| Alcohol or Drug Abuse | | | |
| Ulcers, Hernias | | | |
| Gallbladder Problems | | | |
| Accidents / Operations | | | |
| Birth Defects | | | |
| Vein Problems | | | |
| Hepatitis | | | |
| Other (specify) | | | |

| HISTORY SINCE LAST MENSTRUAL PERIOD | YES | NO | (Include date and type of treatment) |
|---|---|---|---|
| Nausea | | | |
| Vomiting | | | |
| Constipation | | | |
| Indigestion | | | |
| Headache | | | |
| *Bleeding (specify) | | | |
| Vaginal Discharge | | | |
| Herpes Outbreak | | | |
| Emotional / Family Problems | | | |
| Abdominal Pain | | | |
| Swelling | | | |
| Urinary Complaints | | | |
| German Measles | | | |
| Other Virus or Infections | | | |
| X-rays (specify) | | | |
| Accidents / Operations | | | |
| Medications (specify) | | | |
| Eye Glasses or Contacts | | | |
| Removable Dental Work | | | |
| Cat Owner | | | |
| | | | |

| | Amount and Frequency | Comments |
|---|---|---|
| Alcohol | | |
| *Tobacco | | |
| Marijuana | | |
| Cocaine | | |
| Heroin, other drugs | | |
| Caffeine | | |
| Artificial Sweeteners | | |
| Milk Products (daily) | | |
| | | |

For items you have checked "YES," list which of your **BLOOD** relatives(s) had the problem.

| YES | NO | Your Family History | Who |
|---|---|---|---|
| | | Diabetes | |
| | | Twins | |
| | | Breast Cancer | |
| | | Uterine, Cervical Cancer | |
| | | Other Cancer (specify) | |
| | | Mental Retardation | |
| | | Birth Defects | |
| | | High Blood Pressure | |
| | | Heart Disease | |
| | | Sickle Cell | |
| | | Kidney Disease | |
| | | Mental Problems | |
| | | Allergies | |
| | | Tuberculosis | |
| | | Easy Bleeder | |
| | | Your Mother took DES while pregnant* | |

## Genetic History – Both YOUR family AND Father of baby's family

For items you have checked "YES," note which relative and whose side of family (yours or father of baby's).

| YES | NO | | Relatives |
|---|---|---|---|
| | | Mental Retardation | |
| | | Down's Syndrome (mongoloid) | |
| | | Spina Bifida or Meningomyelocele (open spine) | |
| | | Hemophilia | |
| | | Muscular Dystrophy | |
| | | Tay-Sachs Disease | |
| | | Sickle Cell or Sickle Cell Trait | |
| | | Other Genetic or Familial Disease | |
| | | Stillborns | |
| | | Have you, or baby's father in a previous marriage had 3 or more spontaneous miscarriages? | |
| | | Have you, or baby's father had a child born dead, or alive with a birth defect not listed above? | |
| | | Do you, or baby's father have any close relatives descended from Jewish people who lived in Eastern Europe (Azhkenazic Jews)? | |
| | | Will you be age 35 or older when baby is due? | |
| | | If you answered "Yes" to any of the above, do you wish to talk with a genetic counselor? | |
| | | Do you want an AFP blood test to help a baby with an open spine? (See Brochure) | |

I have completed the above sections to the best of my knowledge and will discuss any questions with my physician.

Patient's Signature _____ Date_____

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| SUMMARY OF PREVIOUS PREGNANCIES | FULL TERM | PREMATURE | ABORTION/MISCARRIAGES | NOW ALIVE | TWINS/TRIPLETS |
|---|---|---|---|---|---|
| | | | | | |

| | YEAR | HOSPITAL | WEEKS GESTATION | NUMBER HRS. IN LABOR | VAGINAL OR CESAREAN | SEX | BIRTH WEIGHT | MOTHER'S TOTAL WEIGHT GAIN | RECEIVED RHOGAM INJECTION? | COMPLICATIONS | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | MOTHER | INFANT |
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |

## PAST PREGNANCIES

| COMPLICATIONS | YES | NO | WHICH PREGNANCY | Comments |
|---|---|---|---|---|
| Gestational diabetes | | | | |
| High Blood Pressure | | | | |
| Toxemia | | | | |
| Rh problems | | | | |
| Bleeding during pregnancy | | | | |
| Excess amniotic fluid | | | | |
| *Incompetent cervix | | | | |
| *Premature ruptured membranes | | | | |
| *Premature labor | | | | |
| Kidney Infection | | | | |

| COMPLICATIONS | YES | NO | WHICH PREGNANCY | Comments |
|---|---|---|---|---|
| Bladder Infections | | | | |
| Vein Problems | | | | |
| Anemia (low blood) | | | | |
| Persistent vomiting | | | | |
| Smoked | | | | |
| Drug use | | | | |
| Infant – birth defect | | | | |
| Breech delivery | | | | |
| | | | | |
| | | | | |

I have completed the above sections to the best of my knowledge and will discuss any questions with my physician.

Patient's Signature _____ Date _____

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## PHYSICIAN TO COMPLETE THIS NEXT SECTION

| PHYSICAL EXAMINATION | NORMAL | ABNORMAL |
|---|---|---|
| 1. Skin | | |
| 2. HEENT | | |
| 3. Mouth | | |
| 4. Neck | | |
| 5. Thyroid | | |
| 6. Lungs | | |
| 7. Breasts | | |
| 8. Nipples (erect) | | |
| 9. Heart | | |
| 10. Abdomen | | |
| 11. Extremities | | |
| 12. Musculoskeletal | | |
| 13. Neurologic | | |
| 14. Ext. Genitalia | | |

| DETAIL POS. FINDINGS BY NO. | NORMAL | ABNORMAL |
|---|---|---|
| | | |

| | NORMAL | ABNORMAL |
|---|---|---|
| 15. Perineum | | |
| 16. Vagina | | |
| 17. Cervix NULLIP _____ MULTIP _____ | | |
| 18. Cx. Erosion | | |
| 19. L. Adnexa | | |
| 20. R. Adnexa | | |
| 21. Uterus POSITION _____ SIZE _____ | | |
| 22. Rectum | | |

**PELVIC MEASUREMENTS**

| | Adequate | Borderline | Contracted |
|---|---|---|---|
| Inlet | | | |
| Mid Pelvis | | | |
| Outlet | | | |

Prognosis for delivery

Initial overall evaluation of patient

Physician _____ Date _____

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