Date: _____

Sandpoint Women's Health

New OB Patient Health History Form

Please don't leave any section blank. If none or not applicable, write N/A.

Patient Name _____ Date of Birth _____/_____/_____ Age _____

Religious Preference _____ Occupation _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Partner ☐ Jewish ancestry: Yes / No

Ethnicity: _____ Height: _____' _____"

Father of the baby: Name _____ Age _____ Height ___' ____" Weight _____
Occupation _____ Ethnicity: _____ Jewish ancestry: Yes / No

Menstrual History

First day of last menstrual period _____/_____/_____ Unknown ☐ Age at first period _____

Periods regular ☐ irregular ☐ Days between periods _____ How long do periods last _____

Are periods heavy ☐ moderate ☐ light ☐ Spotting since last period? Yes / No When _____

Reproductive History

List previous pregnancies in order. Please include abortions (TAB) and/or miscarriages (SAB)

Delivery date M/D/YR	**Place of Birth**	**# of weeks Pregnant**	**Length of Labor**	**Type of Meds used**	**Vaginal or C-section**	**Birth Weight**	**Sex of Baby**	**Complications**

Date of last Pap Smear _____ Never had one ☐ Ever have an abnormal Pap Yes / No

If yes to an abnormal Pap, were you treated: Cryotherapy ☐ Laser ☐ Cone Biopsy ☐ LEEP ☐

Have you been told you have a Uterine Anomaly (ie: tilted, retroverted, heart shape) Yes ☐ No ☐

Have you ever experienced Sexual Abuse or trauma? Never ☐ Past _____ Current_____

Have you ever been physically abused? Never ☐ Past _____ Current_____

Have you ever been mentally abused? Never ☐ Past _____ Current_____

Have you or the father of the baby EVER had a sexually transmitted disease. (Even treated)

STD	**YOU**	**FOB**	**STD**	**YOU**	**FOB**	**Comments**
Chlamydia			HPV			
Gonorrhea			Genital Herpes			
Syphilis			HIV			
Genital Warts			Trich			

Past Medical History

This is <u>your</u> history only. Answer yes if you ever have or have had these and the year diagnosed.

	Yes	No	Year		Yes	No	Year
Diabetes				Hepatitis/ Liver Disease			
Anemia				Varicose Veins/ Phlebitis			
Hypertension				Thyroid dysfunction			
Heart Disease				Trauma/Motor Vehicle Accident			
Autoimmune Disorder				History Blood Transfusions			
Kidney Disease/ UTI's				Rhogam for Negative blood			
Neurologic/ Epilepsy				Pulmonary (TB, Asthma)			
Psychiatric/ Mood Disorder				Chicken Pox			
Depression				Eating Disorder			
Migraines				**Other:**			

Past Surgical History

List all surgeries and their year: NONE ☐

Surgeries Year

_____ _____

_____ _____

_____ _____

_____ _____

Medications/supplements

<u>Name</u>	**Dose**	**<u># times a day</u>**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical allergies:

_____ Latex: Y / N Eggs: Y / N NONE ☐

Family Medical History

Please list: (F)father, (M)mother, (PGF) paternal grandfather, (PGM) paternal grandmother, (MGF)maternal grandfather, (MGM)maternal grandmother, (S) sibling, (A) aunt, (U) uncle etc.
<u>Add age of diagnosis if known.</u>

Diabetes _____ Ovarian Cancer_____

Heart Disease_____ Endometrial Cancer_____

High Blood Pressure_____ Colon Cancer_____

Lung Disease_____ Thyroid Disease_____

Breast Cancer _____

Other family medical history_____

Social History

Are you a smoker Yes ☐ No ☐ Never ☐ How much before Pregnancy_____ Now_____

Alcohol Yes ☐ No ☐ Never ☐ How much before Pregnancy _____Now_____

Street Drugs (including marijuana) Yes ☐ No ☐ Never ☐ Type_____

Genetic History

Include patient, baby's father, or anyone in either family with:

	Yes	No		Yes	No
Patient's age 35 yrs or older			Huntington Chorea		
Thalasseinia (Italian, Greek, Med, Asian)			Mental Retardation/ Autism		
Neural Tube Defect(Spina Bifida, or Anencephaly)			Inherited Genetic or Chromosomal Disorder		
Congenital Heart Defect			Maternal Metabolic Disorder		
Down Syndrome			Patient or baby's father had child with birth defect not listed		
Tay-Sachs (Jewish, Cajun, French-Canada)			Recurrent miscarriage or stillbirths		
Sickle Cell Disease (African)			Medications/ Street Drugs/ alcohol since last period		
Hemophilia			If Yes, What?		
Muscular Dystrophy					
Cystic Fibrosis			Other:		

List any symptoms you have been having with this pregnancy:

_____

_____

Are there cats in the home? Yes / No If Yes, who changes the cat box? _____

Are you around children on a regular basis? Yes / No

What do you do for exercise? _____

Please list any questions you may have regarding pregnancy:

_____

_____

_____

_____

BONNER GENERAL HEALTH

Sandpoint Women's Health