OB-GYN & MIDWIFERY
ASSOCIATES OF ITHACA

Your Last Name______________________________ Your First Name ____________________ Age _______

Date of Birth________________ Occupation____

Father of Baby or Partner's Name____ Age_______

Father of Baby or Partner's Occupation____

Primary Support Person's Name (If not listed above) ____

MENSTRUAL

First day of your last menstrual period ____________________ Was it a normal period? _______ Is this a planned pregnancy?_________

Your weight prior to pregnancy: ________________________

If you have recently taken birth control, when did you stop? ______________________________

If you have had a positive pregnancy test, when and where was it done? ____

Have you received prenatal care from any other office for this pregnancy?______
If yes, approximate number of weeks pregnant at your first visit:_____ Approximate number of visits total _______

Age at your first period?_________ Number of days between cycles ____________ Number of days of bleeding___________________

When was your last Pap?_________________
Ever had an abnormal Pap?_______________

Ever had: ☐ Chlamydia ☐ Herpes ☐ Genital warts ☐ Syphilis ☐ None of these

PREGNANCY HISTORY

Please describe all previous pregnancies. ☐ I have never been pregnant before

DATE	PLACE OF DELIVERY	BABY'S NAME	WEIGHT	SEX	VAGINAL or C/section?	LENGTH OF LABOR	COMPLICATIONS

DATE	MISCARRIAGE	ABORTION	COMPLICATIONS

Indicate any conditions you had during any previous pregnancies:

☐ None of these ☐ Pre-eclampsia
☐ Diabetes ☐ Pre-term labor
☐ Birth defects ☐ Infertility

YES	NO	
		Does this pregnancy have the same father as the previous pregnancies?
		Have you received any X-rays since your last menstrual period?
		Do you have any concerns regarding this pregnancy? (If yes, describe below.)

Comments:

MEDICAL HISTORY

Your primary care provider's name ____________________

LAST NAME	FIRST NAME

Have you ever had ☐ Chicken pox ☐ Fifth disease ☐ German measles ☐ **None of these**

Indicate any conditions you have, or have had in the past

☐ High blood pressure	☐ Asthma	☐ Stomach ulcers	☐ Kidney stones	☐ Arthritis
☐ Seizures	☐ Depression or anxiety	☐ Skin cancer	☐ Heart disease	☐ Tuberculosis
☐ Colitis	☐ Kidney disease	☐ Joint problems	☐ Migraine headache	☐ Mental illness
☐ High cholesterol	☐ Lung disease	☐ Gall bladder problems	☐ Back injury / pain	☐ Numbness/tingling
☐ Alcoholism	☐ Eczema / psoriasis	☐ Blood clots	☐ Diabetes	☐ Liver problems
☐ Urinary incontinence	☐ Broken bones	☐ Breast lump / pain	☐ Drug use / abuse	☐ Stroke
☐ Thyroid problems	☐ Hepatitis	☐ Autoimmune disease	☐ Osteoporosis	☐ Cancer
☐ Blood transfusion	☐ NONE OF THESE	☐ Other (describe below)		

List any surgeries you have had ☐ **Have not had surgery**

DATE	TYPE OF SURGERY	ANY COMPLICATIONS?

List all medications you are currently taking ☐ **None**

____

List any medications you have recently taken before you found out you were pregnant ☐ **None**

____

DRUG ALLERGIES

☐ No drug allergies

TO WHAT	REACTION

ENVIRONMENTAL ALLERGIES

☐ No environmental allergies

TO WHAT	REACTION

Do you have any **latex allergy** or sensitivity? ☐ No ☐ Yes Reaction ____________________

Indicate **vaccines** you've had ☐ Hepatitis B ☐ Tdap ☐ Influenza (flu) ☐ **None of these** ☐ HPV ☐ Not sure ☐ Rubella (or MMR) ☐ Varicella (chicken pox)

FAMILY HISTORY

Please complete with information about your **biological** family members:

Your Father	☐ Healthy	☐ Deceased. Cause of Death:
Your Mother	☐ Healthy	☐ Deceased. Cause of Death:
Brother(s) Number: _________	☐ Healthy	☐ Deceased. Cause of Death:
Sister(s) Number: _________	☐ Healthy	☐ Deceased. Cause of Death:
Your Father's mother (Paternal grandmother)	☐ Healthy	☐ Deceased. Cause of Death:
Your Father's father (Paternal grandfather)	☐ Healthy	☐ Deceased. Cause of Death:
Your Mother's Mother (Maternal grandmother)	☐ Healthy	☐ Deceased. Cause of Death:
Your Mother's Father (Maternal grandfather)	☐ Healthy	☐ Deceased. Cause of Death:
Your Children	☐ Healthy	☐ Deceased. Cause of Death:

Any other significant family history? Describe:

____

Revised 8/2016

SOCIAL HISTORY

LAST NAME FIRST NAME

Marital status ______________________

Highest level of education you completed ______________________

Who lives in your household? ______________ Number & type of pets ______________

Your primary language ______________ Your regular diet/ modifications ______________

Any potentially dangerous exposures at work? __________ Any ongoing renovations at home or work? __________

CAFFEINE	TOBACCO		ALCOHOL	DRUG USE
Caffeinated Coffee cups/day	Amount per day	Number of yrs of use:	Type & number of drinks per week prior to pregnancy	Any drug use during pregnancy? ☐ No ☐ Yes What substances?
Caffeinated Tea cups/day	☐ Quit when became pregnant ☐ Quit in past, prior to pregnancy Date quit __________ ☐ Have never smoked		Amt per week since pregnancy known:	How much per day /week?
Caffeinated Soda servings/day				

How often do you use a seatbelt when driving or riding in a vehicle? ☐ Always ☐ Sometimes ☐ Never
Do you have any concerns regarding your relationship and/or your safety? ☐ No ☐ Yes

YES	NO	GENETIC SCREENING	RECENT TRAVEL
		Will you be 35 years or older when the baby is due?	Have you or the father of the baby traveled **out of New York state** in the past 6 months? ☐ No ☐ Yes Where?
		Do you, the baby's father, or a family member have a birth defect?	
		Do you or the baby's father have family members with mental retardation?	

Indicate any conditions in your or the baby's father's family:

☐ Down Syndrome ☐ Spina Bifida ☐ Hemophilia ☐ Huntington's Chorea ☐ Muscular Dystrophy ☐ **NONE**

☐ Other genetic disorders: ______________________

YES	NO	
		Have you ever had a stillborn child or recurrent miscarriage?
		Have you or the baby's father ever had a chromosomal study done?
		Have you ever been tested for cystic fibrosis? **If yes,** are you a carrier? ☐ Yes ☐ No
		Are you or the baby's father of Jewish descent? **If yes,** have either of you been tested for Tay Sach's disease ☐ Yes ☐ No
		Are you or the baby's father of Italian, Greek, or Mediterranean descent? **If yes**, have either of you been tested for B-thalassemia? ☐ Yes ☐ No
		Are you or the baby's father of Philippine or Southeast Asian descent? **If yes**, have either of you been tested for A-thalassemia? ☐ Yes ☐ No
		Are you or the baby's father of African descent? **If yes**, have either of you been tested for sickle cell anemia? ☐ Yes ☐ No

How do you and the baby's father describe your hereditary backgrounds (e.g. German, Chinese, Russian, Portuguese, etc.)

Self ______________________ Father of baby ______________________

ADDITIONAL INFORMATION

☐ Yes ☐ No Were you born outside of the United States?

☐ Yes ☐ No Do you ever eat clay, soil, plaster, paint chips?

☐ Yes ☐ No Do you frequently crave ice chips?

☐ Yes ☐ No Do you eat fish more than 2-3 times a week?

☐ Yes ☐ No Do you use imported spices, foods, cosmetics, ceramics, or folk remedies?