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

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	☐ Ezcema / 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)		

Indicate any diseases which you have HAD ☐ Chicken pox ☐ Fifth disease ☐ German measles ☐ **None of these**

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 vaccinations you've had ☐ Hepatitis B ☐ Influenza ☐ HPV ☐ Rubella ☐ Varicella ☐ Tdap ☐ **None of these** ☐ Not sure

FAMILY HISTORY

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

Your Son(s)	☐ Healthy	☐ Deceased. Cause of Death:
Your Daughter(s)	☐ Healthy	☐ Deceased. Cause of Death:
Your Brother(s)/Sister(s)	☐ Healthy	☐ Deceased. Cause of Death:
Your Mother	☐ Healthy	☐ Deceased. Cause of Death:
Your Father	☐ 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 Father's mother (Paternal grandmother)	☐ Healthy	☐ Deceased. Cause of Death:
Your Father's father (Paternal grandfather)	☐ Healthy	☐ Deceased. Cause of Death:
Other close relatives on your mother's side	☐ Healthy	☐ Deceased. Cause of Death:
Other close relatives on your father's side	☐ Healthy	☐ Deceased. Cause of Death:

Any other significant family history? Describe:

_____

SOCIAL HISTORY

Marital status:

Who lives in your household?

LAST NAME FIRST NAME

Pets in your home:

Highest level of education you completed _____

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

Your regular diet/ modifications _____

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

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	LANGUAGE
		Will you be 35 years or older when the baby is due?	Have you traveled outside the US in the past 6 months? ☐ No ☐ Yes Where?	What is your primary language?
		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 frequently crave ice chips?

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

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

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