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 |
|---|---|---|---|---|---|---|---|
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| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

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

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<br>☐ Quit in past, prior to pregnancy<br>☐ Have never smoked | Amt per week since pregnant:<br>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 |
|---|---|---|
| | | Will you be 35 years or older when the baby is due? |
| | | 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?<br>**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?<br>**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?