

**MARYSVILLE OBSTETRICS & GYNECOLOGY, INC.
PATIENT HISTORY FORM**

DATE: _____

NAME (LAST, FIRST, MI): _____

HOSPITAL OF DELIVERY: _____

CONTACT NUMBER: _____

REFERRED BY: _____

NEWBORN'S PHYSICIAN: _____

FINAL EDD: _____

PRIMARY PROVIDER/GROUP: _____

BIRTH DATE (M/D/Y): AGE: RACE: MARITAL STATUS: S M W D SEP OCCUPATION:	ADDRESS: ZIP: PHONE (H): (O): INSURANCE CARRIER/MEDICAID #: POLICY #: EMERGENCY CONTACT:
LANGUAGE:	
HUSBAND/DOMESTIC PARTNER:	
FATHER OF THE BABY:	

TOTAL PREG:	FULL TERM:	PREMATURE:	AB, INDUCED:	AB, SPONTANEOUS:	ECTOPICS:	MULTIPLE BIRTHS:	LIVING:
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MENSTRUAL HISTORY:

LMP

<input type="checkbox"/> DEFINITE	<input type="checkbox"/> APPROXIMATE (MONTH KNOWN)	MENSES MONTHLY <input type="checkbox"/> YES <input type="checkbox"/> NO	FREQUENCY: _____ DAYS
<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> NORMAL AMOUNT/DURATION	PRIOR MENSES: _____ (Date)	ON BCP AT CONCEPT <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> FINAL _____		MENARCHE: _____ (AGE ONSET)	hCG + ____/____/____

PAST PREGNACIES (LAST SIX):

DATE M/Y	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR Y/N	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY:

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT		○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES					17. D (Rh) SENSITIZED
2. HYPERTENSION					18. PULMONARY (TB, ASTHMA)
3. HEART DISEASE					19. SEASONAL ALLERGIES
4. AUTOIMMUNE DISORDER					20. DRUG/LATEX ALLERGIES/REACTIONS
5. KIDNEY DISEASE/UTI					21. BREAST
6. NEUROLOGIC/EPILEPSY					22. GYN SURGERY
7. PSYCHIATRIC					23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)
8. DEPRESSION/POSTPARTUM DEPRESSION					24. ANESTHETIC COMPLICATIONS
9. HEPATITIS/LIVER DISEASE					25. HISTORY OF ABNORMAL PAP
10. VARICOSITIES/PHLEBITIS					26. UTERINE ANOMALY/DES
11. THYROID DYSFUNCTION					27. INFERTILITY
12. TRAUMA/VIOLENCE					28. RELEVANT FAMILY HISTORY
13. HISTORY OF BLOOD TRANSFUS.					29. OTHER
	○ Neg. + Pos.	AMT/DAY PREPREG	AMT/DAY PREG	# OF YEARS	
14. TOBACCO					
15. ALCOHOL					
16. ILLICIT/RECREATIONAL DRUGS					

COMMENTS: _____

SYMPTOMS SINCE LMP

Name: _____

D.O.B. _____

GENETIC SCREENING/TERATOLOGY COUNSELING
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS AS OF ESTIMATED DATE OF DELIVERY			12. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV < 80			13. MENTAL RETARDATION/AUTISM IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANENCEPHALY)			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENITAL HEART DEFECT			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
5. DOWN SYNDROME			16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)			17. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
7. CANAVAN DISEASE			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OF OTC DRUGS) ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD IF YES, AGENTS AND STRENGTH/DOSAGE		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			19. ANY OTHER		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS					
10. MUSCULAR DYSTROPHY					
11. CYSTIC FIBROSIS					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. OTHER (See Comments)		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD					

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION

DATE	HEIGHT	BP			
1. HEENT <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	12. VULVA <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		<input type="checkbox"/> CONDYLOMA	<input type="checkbox"/> LESIONS	
2. FUNDI <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	13. VAGINA <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> DISCHARGE	
3. TEETH <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	14. CERVIX <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> LESIONS	
4. THYROID <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	15. UTERUS SIZE _____ WEEKS			<input type="checkbox"/> FIBROIDS	
5. BREASTS <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	16. ADNEXA <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		<input type="checkbox"/> MASS		
6. LUNGS <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	17. RECTUM <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		<input type="checkbox"/> ABNORMAL		
7. HEART <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	18. DIAGONAL CONJUGATE <input type="checkbox"/> REACHED <input type="checkbox"/> NO			_____ CM	
8. ABDOMEN <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	19. SPINE <input type="checkbox"/> AVERAGE <input type="checkbox"/> PROMINENT		<input type="checkbox"/> STRAIGHT	<input type="checkbox"/> BLUNT	
9. EXTREMITIES <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	20. SACRUM <input type="checkbox"/> CONCAVE <input type="checkbox"/> STRAIGHT		<input type="checkbox"/> WIDE	<input type="checkbox"/> ANTERIOR	
10. SKIN <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	21. SUBPUBIC ARCH <input type="checkbox"/> NORMAL <input type="checkbox"/> WIDE		<input type="checkbox"/> NO	<input type="checkbox"/> NARROW	
11. LYMPH NODES <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	22. GYNECOID PELVIC TYPE <input type="checkbox"/> YES <input type="checkbox"/> NO				

COMMENTS (Number and explain abnormals) : _____

EXAM BY _____