DuPage Medical Group
Obstetrics & Gynecology

Obstetric Health History

Date: _____
Name: _____Date of Birth:_____ Religion/Culture:_____
Telephone Numbers: Home _____Cell _____Work_____
Occupation: _____Education Obtained: _____
Primary Language Spoken: □ English □ Spanish □ Other _____
FIRST DAY OF LAST MENSTRUAL PERIOD _____
LAST PAP SMEAR _____
DATE OF POSITIVE PREGNANCY TEST _____
ALLERGIES _____

Copied/Sent to L&D
Date:_____Init.:_____

PAST MEDICAL HISTORY

Have you ever had any of the following?	**YES**	**NO**
Diabetes: □ During pregnancy □ Before pregnancy		
High blood pressure: □ During pregnancy □ Before pregnancy		
Heart: □ Disease □ Murmur □ Valve Prolapse □ Rheumatic Heart Disease		
Kidney: □ Disease □ Urinary Tract Infections		
Lung: □ Asthma □ Chronic Disease □ TB		
Liver: □ Disease □ Hepatitis		
Blood: □ Transfusion □ RH Disease □ Clots in Vein □ Clot in Lung □ Phlebitis		
Immune: □ Thyroid □ Autoimmune (Lupus) □ HIV or AIDS		
Neuro/Psych: □ Seizures (Epilepsy) □ Post-Partum Depression □ Depression □Psychiatric Illness		
Do you feel safe in your home?		
Have you ever been physically or emotionally abused?		
Alcohol Use (specify average # drinks per day): #		
Tobacco Use (specify # cigarettes per day & years of usage): # Yrs		
Street Drug Use (list with date of last usage):		

GENETIC HISTORY

Do you, the baby's father, or any relative of either of you, have the following	**YES**	**NO**
Come from: □ Greece □ Italy □ North Africa □ the Orient …**AND** have anemia called Thalassemia		
Brain or spinal cord defects (neural tube defects)		
Down Syndrome		
Heritage: □ Jewish □ French Canadian □ Tay Sachs or Canavans Disease concern		
Black-African Heritage (Sickle Cell)		
Bleeding Disorders (Hemophilia)		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
□ Mental Retardation □ Tested for Fragile X □ Autism □ PKU		
Other genetic or chromosomal disorders (i.e.: cleft lip or palate, congenital heart malformation)		
□ Miscarriage after the 3rd month of pregnancy - (specify # of times):		
□ Stillborn - # of times: □ Repetitive early miscarriages – (specify # of times):		
Are you 34 or more years old?		
Do you or the baby's father have a birth defect?		
If so, explain:		

Misc.	**YES**	**NO**
Would you accept blood if needed in case of emergency?		
Are you or father of baby blood relatives?		

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Name: _____ Date of Birth:_____

INFECTION HISTORY

Do you now, or have you in the past had:	**YES**	**NO**
A cat at home? □ Indoor Only		
Work with developmentally handicapped children?		
□ Tetanus Vaccine Date of Last Booster _____		
□ Chicken Pox □ Chicken Pox Vaccine □ Hepatitis Vaccine		
□ Tattoo □ Body Piercing		
Live or lived with someone with TB?		
Had a rash, viral illness, or a high fever since your last period?		
A sexually transmitted infection such as: □ Gonorrhea □ Syphilis □ Chlamydia □ Herpes		
Your sexual partner had genital herpes?		
Been in a high risk activity for catching AIDS such as: □ had intercourse with a street drug user □ used street drugs □ had intercourse with a homosexual □ worked as a prostitute		

Please list your pregnancies in chronological order, including miscarriages and terminations:

Child's Name	**Sex M/ F**	**Delivery Date**	**Weeks At Delivery**	**Hours Of Labor**	**Type of Pain Relief**	**Baby's Weight**	**Preterm Labor (Y/N)**	**Hospital**	**Delivering MD**	**Delivery Type* or Problems**

***Forceps/Vacuum, Normal vaginal, Cesarean**

GYNECOLOGIC HISTORY

Have you ever had any of the following?	**YES**	**NO**
□ Abnormal Pap □ Colposcopy □ LEEP □ Other Treatment		
□ Infertility		
□ Pelvic Infection		
□ DES Exposure		
□ Abnormal Uterus □ Fibroids □ Weak Cervix		
□ Female Organ Operations (list with dates):		
□ Other Operations (list with dates):		
□ Cancer (list type(s):		
□ Other hospitalizations or medical illnesses (list with dates):		

Medications:

Medications (since missed period): □ Prescription □ Non-prescription □ Herbal Preparations

List medications & dosage:

Other comments:

Patient Signature_____
Nurse Reviewer _____Date_____
Physician Reviewer: _____Date_____