Jackson Regional Women's Center

OB/GYN PATIENT HISTORY

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Date Form Completed: _____

*IF YOU'RE UNCOMFORTABLE ANSWERING QUESTIONS, LEAVE THEM BLANK; YOU CAN DISCUSS THEM WITH YOUR DOCTOR OR NURSE.

Referring Physician: _____ Phone #: _____
*IF WE ARE UNABLE TO REACH YOU BY MESSAGE, REGARDING YOUR MEDICAL RECORD, WE CAN LEAVE A MESSAGE WITH _____ AT THE PHONE NUMBER _____.

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list: _____
   _____
   _____

2. Please mark any condition that you have or have had in the past:
   - ☐ Cancer
   - ☐ HIV/AIDS
   - ☐ Diabetes
   - ☐ Epilepsy
   - ☐ Thyroid Disorder
   - ☐ Eating Disorder
   - ☐ Heart Disease
   - ☐ Headaches
   - ☐ Depression
   - ☐ High Blood Pressure
   - ☐ Arthritis or Lupus
   - ☐ Asthma
   - ☐ Kidney Disease
   - ☐ Frequent Infections
   - ☐ Anemia
   - ☐ Hepatitis
   - ☐ Herpes
   - ☐ Bowel Disease
   - ☐ Von Willebrands (e.g:phlebitis)
   - ☐ Recurrent Urinary Tract Infection

   Describe, if needed: _____
   _____
   _____

3. Please indicate any surgeries or hospitalizations that you have had:_____
   _____
   _____
   _____

4. Do you or any family member have a history of problems with anesthesia? ☐ Yes ☐ No
   If yes, please describe: _____
   _____
   _____

5. Do you have any religious objections to any form of medical treatment (Ex: Jehovah's Witness, refusal of blood transfusion)? ☐ Yes ☐ No
   If yes, please describe: _____
   _____
   _____

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REVIEW YOUR PREGNANCY HISTORY

1. List the number of times you have been pregnant _____
2. List the number of times you have delivered _____
3. List how many c-sections you have had _____
4. List the number of times you lost the pregnancy (including miscarriage, elective abortion, tubal pregnancy, etc) _____
5. Did you have diabetes in your pregnancy? ☐ Yes ☐ No

EXPOSURE AFFECTING HEALTH

1. Do you smoke Cigarettes? ☐ Yes ☐ No If yes, how many packs a day? _____
   If you are a former smoker, when did you quit? _____
2. Do you drink alcoholic beverages before you became pregnant? _____
3. Do you drink alcoholic beverages now? _____
   (1.5 oz spirits = 12 oz beer) If yes, how often? _____
   What type of drinks? _____
4. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, any herbal medicines, and their dosage: _____
   _____
   _____
5. Please list any illicit or recreational drugs used since your last period (e.g: cocaine, marijuana, LSD, heroin, crack, etc): _____
   _____
   _____
6. Do you have any reason to believe you may have been exposed to AIDS (e.g: history of blood transfusion, intravenous drug use, multiple sexual partners or sexual partner to a gay or bisexual male, exposure to an intravenous drug user)? ☐ Yes ☐ No
   If yes, please describe: _____
   _____
   _____
7. Are you being exposed to chemicals or radiation (e.g: X-Rays)? ☐ Yes ☐ No
   If yes, please describe: _____
   _____
   _____

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GYNECOLOGIC HEALTH HISTORY

- Last Menstrual Period _____ Type of Birth Control _____
- Do you perform monthly self-breast exams? ☐ Yes ☐ No
- When was your LAST Pap smear test? _____
- Have you ever had an abnormal Pap test? ☐ Yes ☐ No
  If yes, when were you treated? _____
  How were you treated? _____
  What was the diagnosis? _____

- Have you ever had: ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease
  If yes, when? _____ How? _____
  Where were you treated? _____
  What was the diagnosis? _____
- Have you ever had Herpes? _____ ☐ Yes ☐ No
  If yes, how often do you have outbreaks? _____
- Have you ever had Syphilis? _____ ☐ Yes ☐ No
  If yes, when? _____ How? _____
  Where were you treated? _____
- Have you ever used an IUD (intrauterine device) for contraception? ☐ Yes ☐ No
  If yes, please describe when _____
  What treatment was received: _____

FAMILY HISTORY & GENETIC SCREENING

1. What is your race? _____ What's the race of the baby's father? _____
2. What is the name of the baby's father? _____
3. What is your marital status to the baby's father? _____
4. Have you or the baby's father had a child born with a birth defect? ☐ Yes ☐ No
   If yes, please describe: _____
   _____
5. Did you or the baby's father have a birth defect? ☐ Yes ☐ No
   If yes, please describe: _____
   _____
6. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (e.g: mental retardation, birth defects, early infant death, deformities, or inherited diseases such as: hemophilia, muscular dystrophy or cystic fibrosis):
   Birth Defect ☐ Yes ☐ No Early Infant Death ☐ Yes ☐ No
   Deformities ☐ Yes ☐ No
   Neural Tube Defects:
   Anenocephaly ☐ Yes ☐ No Spina-bifida ☐ Yes ☐ No
   Any other genetic/chromosomal abnormalities not listed above: ☐ Yes ☐ No
   Please specify: _____
   _____
   How is this child/person related to you? _____

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PERSONAL AND FAMILY HISTORY

(Check all that apply in each category)

Cardiovascular	Patient	Family/Relationship	**Renal Disease**	Patient	Family/Relationship
Heart Disease			Cystitis		
Rheumatic Fever			Pyelonephritis		
Mitral Valve Prolapse			Asympotomatic Bacteruria		
Chronic Hypertension			Chronic Renal Disease		
Varicosities Thrombophlebitis			Neurologic Disorder		
Previous Pulmonary Embolism			Autoimmune Disease		
Blood Disorders			Cancer		
Anemia			Hemoglobinopathy		
Blood Transfusions			Seizure Disorder		

Other: _____

Pulmonary	**Patient**	**Family/Relationship**	**Other**	**Patient**	**Family/Relationship**
Asthma			Psychiatric Disease		
Tuberculosis			Physical Abuse/Neglect		
Chronic Obstructive Pulmonary Disease			Emotional Abuse/Neglect-Addiction (Drug, Alcohol, Nicotine)		

Other: _____

Endocrine	**Patient**	**Family/Relationship**	**Other**	**Patient**	**Family/Relationship**
Diabetes			Major Accidents		
Thyroid Dysfunction			Surgery		
Maternal PKU Endocrinopathy			Anesthetic Complications		
Gastrointestinal			Non-Surgical Hospitalization		
Liver Disease			No Known Disease/Problems		

Other: _____

Genetic History	Patient	Family/Relationship	Other	Patient	Family/Relationship
Age>35(Female)>50 (Male)			Mental Retardation		
Cerebral Palsy			Muscular Dystrophy		
Cleft Lip			Cleft Palate		
Congenital Heart Disease			Sickle Cell Disease/Trait		
Congenital Anomalies			Tay-Sachs Disease		
Consanguinity			Test for Fragile X		
Cystic Fibrosis			Thalassemia A or B		
Down Syndrome			Hemophilia		
Huntingdon's Chorea			Neural Tube Defect		

Other: _____

7. Do you or the baby's father's family have a personal or family history of pregnancy losses (miscarriages, stillbirths)? _____
   If yes, have either of you had genetic counseling? ☐ Yes ☐ No
   If yes, have either of you had a chromosomal test? ☐ Yes ☐ No
   What were the results? _____
   Where were the results?_____

8. Some genetic problems occur in more couples with certain racial or ancestral backgrounds. Please check if you or the baby's father are in one of these backgrounds:
   - Eastern European Jewish (Ashkenazi) ancestry ☐ Yes ☐ No
     If yes, have you had the Tay-Sachs screening test? ☐ Yes ☐ No
     If yes, have you had a Canavan screening test? ☐ Yes ☐ No
     If yes, have you had a Cystic Fibrosis screening? ☐ Yes ☐ No
     If yes, have you had a Familial Dysutonomia screening? ☐ Yes ☐ No
     Date: _____ Result: _____
   - African American ☐ Yes ☐ No
     If yes, have you had the Sickle Cell screening? ☐ Yes ☐ No
     Date: _____ Result: _____
   - European Ancestry & Eastern European (Ashkenazi) ancestry ☐ Yes ☐ No
     If yes, have you had a Cystic Fibrosis screening? ☐ Yes ☐ No
   - Mediterranean ancestry or Southwest Asian ancestry? ☐ Yes ☐ No
     If yes, have you had the screening for inherited forms of anemia, such as, Thalassemia? ☐ Yes ☐ No

9. Please list any other concerns you have about birth defects or inherited disorders:

_____

_____

10. Do you want to have a Down Syndrome Risk Assessment? ☐ Yes ☐ No
11. Is the father 50 years or older? ☐ Yes ☐ No

PSYCHOSOCIAL SCREENING

1. Do you feel safe where you live? ☐ Yes ☐ No
2. Are you exposed to second-hand smoke? ☐ Yes ☐ No
3. In the past 2 months, have you used drugs or alcohol? ☐ Yes ☐ No
   (including beer, wine, or mixed drinks)
4. Have you moved in the past 12 months? _____
   How many times? _____

_____
Print Name

_____
Patient Signature

_____
Date

ATTENTION

- Any patients that are being seen for a problem, pregnancy, or transferring from another doctor, please make sure you have your records BEFORE your appointment. **For better assurance, it is best you call the week before to check if your records have been received.**
- You may also pick the records up and bring them with you to your appointment.
- If you fail to have your records faxed, mailed, or brought at the time of your appointment, **YOU WILL BE ASKED TO RESCHEDULE**. It is very important that our doctors have these records at your first appointment.
- If you have any questions, call our office at (731) 668-4455.
- Our fax numbers are (731) 668-9007 or (731) 664-4508.