Health History Questionnaire- *Obstetrics (Established patient)*

A) **NAME**_____ **Preferred Name:** _____

Age_____ DOB_____

1. Partner Name/DOB: _____
2. Occupation:_____
3. Preferred pharmacy (Store and Street/City): _____

Gyn Provider: [ ] Dr. Smith [ ] Dr. Ryan [ ] Dr. Ruiz [ ] Tracy

B) **CURRENT MEDICATIONS** (include dose/amount per day/medical reason for taking med)

Medication	Dose	Frequency	Reason for medicine

Are you taking a prenatal vitamin? ☐ Yes ☐ No

A) **GYN HISTORY**: Check any that apply or ☐ None

☐ Herpes ☐ HIV/AIDS ☐ Syphilis ☐ Chlamydia or gonorrhea
☐ Genital warts ☐ Trichomonas ☐ Fibroids ☐ Pelvic Inflammatory Dz (PID)

B) **PAST MEDICAL HISTORY**

Any changes to your medical history (since last visit)? ☐ Yes ☐ No _____

C) **PAST SURGICAL HISTORY**

Any changes to your surgical history (since last visit)? ☐ Yes ☐ No _____

D) **PREGNANCY HISTORY** ☐ This is my first pregnancy

Please include any history of miscarriage, abortion, and/or ectopic (tubal) pregnancy

Mo/Year	Delivery Location	Duration of Pregnancy (# of weeks)	Type of Delivery vaginal, c-section, abortion, miscarriage	Delivering Physician	Complications Mother and/or Infant	(Child) Sex	(Child) Birth Weight	(Child) Present Health

1. Last Menstrual Period (first day) _____ ☐ **Exact date** ☐ **Approximate date** ☐ **Unknown**
2. History of high blood pressure/ preeclampsia: ☐ Yes ☐ No
3. History of diabetes (gestational)/ PCOS ☐ Yes ☐ No
4. Recent travel (or planned travel) out of country: ☐ Yes ☐ No
5. Have you had chicken pox? ☐ Yes ☐ No
6. Have you received all standard vaccinations (MMR, flu etc) ☐ Yes ☐ No
7. Do you have pet cats? ☐ Yes ☐ No
8. Have you previously had genetic testing? ☐ Yes ☐ No

E) **SOCIAL HISTORY**: (Do you currently …)

1.	Smoke tobacco/ chew tobacco/ vape:	☐ Yes	☐ No	How many/day? _____
2.	Drink any alcohol:	☐ Yes	☐ No	How many/day? _____
3.	Use any drugs/ history of recent use:	☐ Yes	☐ No	What substance: _____
4.	Drink caffeinated drinks?	☐ Yes	☐ No	How many/day? _____
5.	Do you currently feel safe?	☐ Yes	☐ No	

F) **FAMILY HISTORY**

Any changes to your medical history (since last visit)? ☐ Yes ☐ No

_____

Any family history of:

Genetic disorder	☐ Yes	☐ No
Birth defects	☐ Yes	☐ No
Mental retardation	☐ Yes	☐ No
Clotting/bleeding prob	☐ Yes	☐ No