Southwest Medical
Part of OptumCare

MRN:	4289193
NAME:	Test, Amy
DOB:	09/17/1981
PCP:	
DATE:	7/6/2022

OBSTERIC MEDICAL HISTORY FORM

Patient Name: Test, Amy Birth Date: 09/17/1981 Age: _____
MRN: 4289193 Today's Date: 7/6/2022 Date of Last Menstrual Period? _____

How many times have you been pregnant? _____ How many miscarriages did you have? _____
How many children have you delivered? _____ How many abortions did you have? _____
How many were born full term (37 weeks or greater)? _____ How many children are currently living? _____
How many were premature (less than 37 weeks)? _____ How many sets of twins? _____

Have you or your partner traveled to a Zika affected Region? ____ Yes ____ No _____ I don't know

PAST PREGNANCIES (LAST SIX)

Pregnancies	Delivery Date Month/Year	Weeks at delivery	Length of labor	Birth Weight	Sex M/F	Vaginal Delivery or C/section	Epidural or General Anesthetic	Hospital of Delivery	Pre-term Labor Yes/No	Complications Yes/No
1										
2										
3										
4										
5										
6										

When was your last Pap Smear? _____/_____/_____ NEVER _____
My last Pap Smear was _____ normal or _____ abnormal or _____ I don't know
Have you ever had any Abnormal Pap Smears? _____ Yes _____ No _____/_____/_____ NEVER _____
When was your last Mammogram? (Ok to give approximate date) _____/_____/_____ NEVER _____
My last Mammogram was ___normal or _____ abnormal or _____ I don't know _____/_____/_____ NEVER _____

Check the follow infections or Sexually Transmitted Disease (STD or Venereal Disease) you have had in the past.

___ None ever ____ Hepatitis (___B or ____ C) ____ Bacterial Vaginosis (Gardnerella) ____ Others: _____

___ Chlamydia ____ Syphilis ____ Human Papilloma Virus (HPV)

___ Gonorrhea (GC, Clap) ____ Trichomoniasis ____ Herpes (____ Genital or ____Oral)

How many Sexual Partners in your lifetime? ___ 0 ___ 1-4 ___ 5 or greater

Were you using birth control? ___ None or _____ (What type)

Marital Status: ____ Single ____ Married ____ Living with Partner ____ Widowed _____ Divorced/ Separated

Occupation: _____ ____ Homemaker ____ Student ____ Retired

What Medications are you currently taking?

Medication Name:	Dosage	Medication Name:	Dosage

List of medications you are allergic to: _____ No known drug allergies:

Medication Name:	Reaction	Medication Name:	Reaction

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OBSTERIC MEDICAL HISTORY FORM

MEDICAL PROBLEMS

	Yes/No		Yes/No
Diabetes		Pulmonary/Asthma/T.B.	
Hypertension		Seasonal allergies	
Heart Disease		Drug/Latex allergic reaction	
Autoimmune Disease		Breast cancer/ OR other issues	
Kidney disease/urinary tract infections		Female Surgery : Myomectomy, Fibroid removal , Ovary removed, Ectopic Pregnancy , LEEP, Cold knife cone, any other female surgery	
Neurologic problems /epilepsy		Operations/Hospitalizations	
Psychiatric problems			
Depression Postpartum depression		Anesthetic complications	
Hepatitis/Liver disease		History of abnormal Pap Smear	
Varicosities/Blood clots		Uterine abnormalities	
Low thyroid/ High thyroid		Infertility	
History of Blood transfusions		Art treatment	
Blood disorders		Pregnancy complications	
Stomach problems		Cancer	
Skin problems		Relevant family history	
D(RH) sensitized			
		Uterine abnormalities	
		Other	

Tobacco use:: Yes / No Amount per pregnancy _____ Amount now _____	Alcohol use: : Yes / No Amount per pregnancy _____ Amount now _____	Illicit/Recreational drugs Yes / No Pre-pregnancy _____ Amount now _____	Sexual Abuse? Yes / No Are you safe now? Yes / No	Domestic Abuse? Yes / No Are you safe now? Yes / No

GENETIC SCREENING

PATIENT HISTORY, FATHER OF THE BABY, OR ANYONE IN EITHER FAMILY

	Yes/No
Age _____> 35 Yrs at delivery date	
Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV < 80	
Neutral tube defect (Meningomyelocele, Spina Bifida, or Anencephaly)	
Congenital Heart Defect Heart Defect	
Down Syndrome	
Tay Sachs (EG, Ashkenazi Jewish, Cajun, French Canadian)	
Canavan Disease (Ashkenazi Jewish)	
Sickle Cell Disease or Trait (African)	
Hemophilia or other blood disorders	
Muscular Dystrophy	
Cystic Fibrosis	
Huntington's Chorea	
Mental Retardation/Autism IF yes was person tested for Fragile X?	
Other Inherited genetic or chromosomal disorder	
Maternal Metabolic Disorder (Type 1 diabetes, PKU)	
Patient or baby's father had a child with birth defects not listed above	
Recurrent pregnancy loss or stillbirth	
Live with someone with TB or exposed to TB	
Patient or partner has history of genital herpes	
Rash or viral illness since last menstral period	
Prior Beta Strep infection in child	
Gonorrhea	

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD

Patient Signature: _____ Medical Provider _____