Women's
Medical Associates of Nashville

New Patient OB Form

Name_____ Age_____ Date of Birth _____ Date_____

PAST MEDICAL HISTORY:

Please list your past and current MAJOR MEDICAL ILLNESSES: NONE_____

1. _____ 3. _____
2. _____ 4. _____

When was your last PAP SMEAR? _____was it normal? YES NO

Do you have any history of ABNORMAL PAP SMEARS? YES NO

If YES, explain_____

Have you ever been diagnosed with any of the following SEXUALLY TRANSMITTED DISEASES? YES NO

HERPES – HIV/AIDS – SYPHILIS – CHLAMYDIA – GONORRHEA (please circle)

PAST SURGICAL HISTORY:

Please list all of your prior SURGERIES (include common surgeries such as c-sections and cosmetic surgery):

	Surgery	Year		Surgery	Year
1.	_____		5.	_____	
2.	_____		6.	_____	
3.	_____		7.	_____	
4.	_____		8.	_____	

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis. Please note any you discontinued for the pregnancy:

	Medication	Dose		Medication	Dose
1.	_____		5.	_____	
2.	_____		6.	_____	
3.	_____		7.	_____	
4.	_____		8.	_____	

Please list all OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS (including prenatals) that you take on a regular basis. Please note any you discontinued for the pregnancy:

1. _____ 3. _____
2. _____ 4. _____

ALLERGIES:

Please list all ALLERGIES TO MEDICATIONS:

	Medication	Reaction (rash, shortness of breath, etc)
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any severe FOOD or ENVIRONMENTAL ALLERGIES you have: _____

Are you allergic to LATEX? YES NO

REPRODUCTIVE HISTORY:

How many TIMES have you been pregnant? _____

How many LIVING CHILDREN do you have? _____

Have you delivered any children PREMATURELY (before 37 weeks)? YES NO

If YES, how many? _____

Have you had any MISCARRIAGES? YES NO

If YES, how many? _____

Have you had any ELECTIVE ABORTIONS? YES NO

If YES, how many? _____

FAMILY HISTORY:

Do you have a FAMILY HISTORY of any of the following problems?

M=mother **F**=father **S**=sister **B**=brother

MGM=maternal grandmother **MGF**=maternal grandfather **PGM**=paternal **grandmother PGF**=paternal grandfather

1.	High blood pressure	YES	NO	**M F S B MGM MGF PGM PGF**
2.	Diabetes	YES	NO	**M F S B MGM MGF PGM PGF**
3.	Heart disease	YES	NO	**M F S B MGM MGF PGM PGF**
4.	Breast cancer	YES	NO	**M F S B MGM MGF PGM PGF**
5.	Ovarian cancer	YES	NO	**M F S B MGM MGF PGM PGF**
6.	Colon cancer	YES	NO	**M F S B MGM MGF PGM PGF**
7.	Thyroid disorder	YES	NO	**M F S B MGM MGF PGM PGF**
8.	Osteoporosis	YES	NO	**M F S B MGM MGF PGM PGF**
9.	Blood clotting disorder	YES	NO	**M F S B MGM MGF PGM PGF**
10.	Deep venous thrombosis (DVT – blood clot deep in leg)	YES	NO	**M F S B MGM MGF PGM PGF**
11.	Autoimmune disorders (such as lupus, rheumatoid arthritis, etc.)	YES	NO	**M F S B MGM MGF PGM PGF**
12.	Other _____			

MENSTRUAL HISTORY:

At what age did you START YOUR PERIODS? _____

When was your LAST MENSTRUAL PERIOD? _____

Describe your periods before your pregnancy:

- Were your periods REGULAR or IRREGULAR?
- How many DAYS were there BETWEEN your cycles? _____
- How many DAYS did your periods LAST? _____
- Were your periods – LIGHT – MODERATE – HEAVY – CLOTS?
- Did you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None Mild Moderate Severe

SOCIAL HISTORY:

Before your pregnancy did you drink ALCOHOL? Rarely Occasionally Daily Never

Do you smoke CIGARETTES? Occasionally Daily Never Quit

Do you use any ILLICIT DRUGS? YES NO

Are you – MARRIED – SINGLE – ENGAGED – WIDOWED – DIVORCED – SEPARATED?

Do you EXERCISE? Regularly Occasionally Never

Are you EMPLOYED outside the home? YES NO

If YES, what type of work do you do (if you are a student please include this information as well)?

_____

What is the name of the FATHER of your baby? _____

What is his OCCUPATION? _____

Do you have any issues with DOMESTIC VIOLENCE? YES NO

Do you wear a SEAT BELT in the car? YES NO

Do you have a RELIGIOUS PREFERENCE? YES NO

If YES, what? _____

REVIEW OF SYSTEMS:

Please circle any SIGNIFICANT SYMPTOMS you currently experience:

NONE

- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other_____
- EYES: blurred vision – eye pain – discharge from eye – other _____
- HEAD & NECK: severe headaches – sore throat – nasal discharge – nose bleeds – decreased hearing – lightheadedness – other _____
- BREAST: lumps – tenderness – nipple discharge – other_____
- CARDIOVASCULAR: chest pain – irregular heart beat – fainting spells – other _____
- RESPIRATORY: shortness of breath – cough – wheezing – other_____
- GASTROINTESTINAL: nausea – vomiting – diarrhea – constipation – heartburn – abdominal pain – blood in stools – incontinence of stools – hemorrhoids – other_____
- GENITOURINARY: urinary frequency – pain with urination – blood in urine – urinary incontinence – difficulty urinating – vaginal discharge – pain with intercourse – bleeding with intercourse – significant PMS – other _____
- SKIN: rash – itching – acne – abnormal hair growth – other_____
- NEURO: headaches – weakness – numbness – other _____
- MUSCULOSKELETAL: joint pain – joint swelling – muscle weakness – muscle pain – other _____
- ENDOCRINE: increased thirst – increased urination – hair loss – heat intolerance – cold intolerance – other_____
- PSYCHIATRIC: anxiety – depression – confusion – other_____
- HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other _____
- ALLERGIC: sinus allergies – skin allergies – other_____

GENETIC SCREENING:

Will you be 35 YEARS OLD or older when the baby is due? YES NO

Do YOU or the FATHER of your baby, or anyone in YOUR FAMILY, on the baby's FATHER'S FAMILY have the following?

- Thalassemia YES NO
- Italian, Greek, Mediterranean, or Asian background YES NO
- Neural tube defect (meningomyelocele, spina bifida, anencephaly) YES NO
- Congenital heart defect YES NO
- Down syndrome YES NO
- Tay Sachs disease YES NO
- Eastern European Jewish or French Canadian background YES NO
- Canavan disease YES NO
- Sickle cell disease or trait YES NO
- Hemophilia or other blood disorder YES NO
- Muscular dystrophy YES NO
- Cystic fibrosis YES NO
- Huntington's chorea YES NO
- Mental retardation YES NO
    - If YES, was the person tested for Fragile X? YES NO
- Other inherited genetic or chromosomal disorder? YES NO
- Maternal metabolic disorder (diabetes, PKU) YES NO

Have YOU or the FATHER of your baby had a CHILD with a BIRTH DEFECT not listed above? YES NO

Do YOU or the FATHER of your baby have a BIRTH DEFECT? YES NO

Do you a history of RECURRENT PREGNANCY LOSS or a STILLBIRTH? YES NO

Have you taken any MEDICATIONS since your last menstrual period other than prenatal vitamins (including vitamins, supplements, over-the-counter-meds, drugs, and alcohol)? YES NO

If YES, please list_____

Have you had any other GENETIC or ENVIRONMENTAL EXPOSURES to discuss? YES NO

INFECTION HISTORY:

Do you live with someone with TB or who has had recent TB EXPOSURE? YES NO

Do you or your partner have GENITAL HERPES? YES NO

Have you had a RASH or VIRAL ILLNESS since your last menstrual period? YES NO

Have you had CHICKEN POX in the past? YES NO

If NO, have you had the CHICKEN POX VACCINE? YES NO

Do you have any CATS at home? YES NO

Do you have any CLOSE CONTACT WITH CHILDREN other than your own on a regular basis? YES NO

I have filled out this form completely and to the best of my ability.

Signature_____ Date_____