Maternal Fetal Medicine
Patient History Questionnaire

Name: _____ Date of Birth: _____

General information/social support (please circle or fill in as appropriate)
I am: single; married; widowed; divorced; separated

Please check all ethnicities that apply:

	PATIENT	FATHER OF BABY
Asian; Southeast Asian	_____	_____
Italian; Greek; Middle Eastern; Mediterranean	_____	_____
Jewish; French Canadian; Cajun	_____	_____
African American; African Descent; Caribbean; Black	_____	_____
Caucasian	_____	_____
Other _____	_____	_____

My occupation is: _____ My highest education level completed: _____

Baby's father's name: _____ Baby's father's occupation: _____

Highest education level completed by baby's father: _____

PAST PREGNANCIES:

Please fill in the following table with information about all past pregnancies. Please include any elective abortions, miscarriages, and/or tubal pregnancies and indicate the year and the approximate stage in pregnancy.

	Date Pregnancy Ended (mo/yr)	Weeks Duration	Vaginal or Cesarean	Hours in Labor	Boy or Girl	Birth Weight	Dr. and Hospital	Spont. or Induced	Living Y/N
1st									
2nd									
3rd									
4th									
5th									
6th									
7th									

Have you had major complications with any pregnancies? _____

Have you had any children with birth defects? _____

MENSTRUAL HISTORY

My last normal period started _____. My periods usually last _____ days.

Birth control pill, birth control patch, or shot use in the last 6 months? Yes No Date stopped? _____

This pregnancy was diagnosed with a: Blood Test: ___ Urine Test: ___ Date of test: _____

MEDICATIONS

I have taken the following prescribed medicines or street drugs since my last menstrual period:

_____

_____

I am currently taking the following medications: _____

_____

Allergies: _____

_____

PAST MEDICAL HISTORY

Mark any of the following conditions that you think you may have had in the past or have now and fill in the blank with family member's relationship to you if you are aware of a family history.
Feel free to put a "?" next to any term that you do not understand.

	Self	Family History	Notes
Diabetes mellitus (please specify)			
Type I Type II Gestational			
High blood pressure			
Heart disease			
Cancer			
Mental condition			
Seizure			
Bladder or kidney infection or stones			
Headaches (tension, migraine)			
Hepatitis or liver disease			
Blood clots in legs or lungs			
Thyroid problems			
Major accidents			
Blood transfusions			
Tuberculosis			
Asthma			
Abnormal Pap smear			
Abnormality of uterus			
Difficulty getting pregnant (infertility)			
PKU or Lupus			
Rheumatic fever			

PAST SURGICAL HISTORY

Have you had any surgeries? If yes, please explain the type of surgery and the approximate date:

_____

_____

Have you ever had complications from anesthesia? If yes, please explain complication:

_____

_____

PERSONAL – SOCIAL HISTORY

I have used street drugs (marijuana, cocaine, methamphetamine, etc.) in the past: Yes No

I have smoked cigarettes within the past year: Yes No
Number of cigarettes/day prior to this pregnancy _____
Number of cigarettes/day now _____

I have had alcoholic beverages within the past year: Yes No
Number of drinks/week prior to this pregnancy _____
Number of drinks/week now _____

RISK FOR HEREDITARY CONDITIONS

Please check all that apply for you, father of the baby, or any relatives:

Yes	No	
___	___	Are you and the father of the baby related?
___	___	There are relatives with Down syndrome or other chromosome problem
___	___	sickle cell disease or trait
___	___	hemophilia (a bleeder)
___	___	muscular dystrophy or neuromuscular disease
___	___	cystic fibrosis
___	___	Huntington's chorea
___	___	mental retardation, learning disability, autism
___	___	other inherited condition or chromosome problem
___	___	other birth defect not listed above
___	___	heart defect at birth
___	___	spina bifida (open spine)
___	___	anencephaly (opening in the head or brain)
___	___	neurofibromatosis
___	___	skeletal disorder
___	___	polycystic kidney disease
___	___	deafness or blindness
___	___	baby who died within 1st year
___	___	2 or more pregnancy losses
___	___	cleft lip/palate

INFECTION HISTORY/RISK

Yes	No	
___	___	I believe I may be at increased risk for AIDS.
___	___	I have been exposed to hepatitis or have lived in the Far East.
___	___	I or my partner have had genital herpes infection.
___	___	I have had a rash or viral illness since my last menstrual period.
___	___	I have had a sexually transmitted disease such as gonorrhea, syphilis or venereal warts.
___	___	I have or have had a cat or have consumed undercooked meat this pregnancy
___	___	I work with young children.
___	___	I would like more information about testing for AIDS.
___	___	I am up to date on my immunizations.
___	___	I have received the Hepatitis B immunization series.

REVIEW OF SYSTEM

At present, do you have any of the following symptoms?

Yes	No		Yes	No	
___	___	Vaginal bleeding	___	___	Heart burn
___	___	Vaginal discharge, itch or odor	___	___	Vomiting/nausea or inability to eat
___	___	Blurry vision; discharge from eyes	___	___	Abdominal pain
___	___	Ringing in ears	___	___	Constipation
___	___	Sore throat/sores in mouth	___	___	Loose stools/change in bowel habits
___	___	Chest pain	___	___	Muscle pain/joint pain
___	___	Shortness of breath/difficulty breathing	___	___	Rash/changes in skin appearance
___	___	Problems or pain with urination	___	___	Depression
___	___	Hair loss	___	___	Seizures
___	___	Hot flashes	___	___	Frequent headaches
___	___	Unexplained weight gain/loss	___	___	Swollen lymph nodes
___	___	Seasonal allergies	___	___	_____
___	___	Illness with fever	___	___	_____

My height is _____. Before this pregnancy, I weighed _____ pounds.

Any additional information that may be important: _____

_____

_____

_____ _____

Patient's signature Date

Thank you for your cooperation in completing this detailed form carefully. It will help us provide better care for your pregnancy.

I reviewed and discussed the medical history with the patient.

_____ _____

Randall Floyd, MD Date

_____ _____

Daniel Jackson, MD Date

_____ _____

Amanda Stephens, MD Date

_____ _____

Hung Winn, MD Date

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