TAHOE FOREST
WOMEN'S CENTER

MRN:

NAME:_____ BIRTH DATE:_____ DATE:_____

Patient History

Checkmark if you have a personal history of the following

Part I		**Yes**	**No**
1.	Diabetes Mellitus		
2.	Heart Problems		
3.	Kidney disease		
4.	Migraine Headaches		
5.	Other neurologic problems		
6.	Crying spells		
7.	Hepatitis		
8.	Varicosities/Phlebitis		
9.	Anemia		
10.	Endocrine problems		
11.	Asthma		
12.	Abuse		
13.	Hypertension		
14.	Autoimmune disease		
15.	Seizures		
16.	Stroke		
17.	Postpartum depression		
18.	Psychiatric problems		
19.	Stomach/bowel problems		
18.	Excessive Bleeding		
19.	Thyroid disease		
20.	Major Accident		
21.	Forced intercourse		

Part II		**Yes**	**No**
1.	Ever Received a blood transfusion		
	Would you refuse a blood transfusion if medically necessary?		
	Would you rather die than receive a transfusion?		
	If yes, for religious reasons?		
2.	Does pt consume any alcoholic beverages?		
	Amount per day_____	-	-
	Amount per day during pregnancy _____	-	-
	Length of use _____	-	-
3.	Is patient's blood type Rh negative		
4.	Had abnormal antibodies in blood		
5.	Ever had tuberculosis		
6.	Ever had breast problems		
7.	History of breastfeeding		
8.	Plan to breastfeed		
9.	Ever had an abnormal PAP smear		
	Does anyone in the patients home use tobacco products		
10.	Does the patient us tobacco products		
11.	If yes, amount per day_____		
	Amount per day during pregnancy _____	-	-
	Length of use _____	-	-
	Does the patient use recreational drugs?	-	-
12.	If yes, amount per day_____		
	Amount per day during pregnancy _____	-	-
	Length of use _____	-	-
13.	Medications pt is allergic or sensitive to		
14.	Ever had anesthetic complications		
15.	Had gynecologic surgical procedures		
16.	Hospitalized for nonsurgical reason other than delivery of a baby		
17.	Any other history of surgical procedures		

Part III		**Yes**	**No**
1.	History of abnormal uterus		
2.	More than 1 year to become pregnant		
3.	Evaluated or treated for		

TAHOE FOREST
WOMEN'S CENTER

MRN:

NAME:_____ BIRTH DATE:_____ DATE:_____

	infertility		
4.	Any symptoms since last period		
5.	History of domestic violence		
6.	History of unplanned pregnancy		
7.	Less than a high school education		
8.	Did mother take DES		
9.	History of family medical problems that may affect pregnancy		
10.	Currently take any medication		
11.	Inadequate prenatal care		
12.	Nutritional risk		
13.	Any other problems of importance to pregnancy		

Genetic Screening		**Yes**	**No**
1.	Is pt 34 years or older		
2.	Interested in info about amnio, CVS Materna 21		
3.	Family history of neural tube defects, such as spina bifida, anencephaly or meningomyelocele		
4.	Has pt, baby's father or anyone in either family had Down's syndrome		
5.	Has pt, baby's father or anyone in either family had hemophilia or any other problems of blood coagulation		
6.	Has pt or baby's father have family history of muscular dystrophy		
7.	Has pt or baby's father have family history of Huntington's Chorea		
	If yes, was the person		
	tested for fragile X		
9.	Has pt or baby's father have family history of maternal metabolic disorder (e.g. insulin-dependent diabetes, PKU)		
10.	Has pt or baby's father have family history of recurrent miscarriage or stillbirth		
11.	Any other genetic risks		
12.	Need info about genetic screening tests		
13.	Screened for thalassemia		
14.	Family history of congenital heart disease or defect		
15.	Has patient or father of baby been screened for Tay-Sachs disease		
16.	Has patient or father of baby been screened for sickle cell disease		
17.	Has pt or baby's father have family history of cystic fibrosis		
18.	Has pt or baby's father have family history of mental retardation or autism		
19.	Any other genetic or chromosomal disorder		
20.	Has patient used drugs, meds, alcohol since last period		

TAHOE FOREST
WOMEN'S CENTER

MRN:

NAME:_____ BIRTH DATE:_____ DATE:_____

	Infection History	**Yes**	**No**
1.	Does pt object to being tested for HIV		
2.	Ever exposed to/treated for tuberculosis		
3.	Ever has a positive skin test for tuberculosis		
4.	Lives with someone who has tuberculosis		
5.	Has genital herpes		
6.	Partner has genital herpes		
7.	Has had a rash or viral disease since last period		
8.	Pt is genital group B streptococcus carrier		
9.	Vaccinated against chicken pox		
10.	Is at risk for chicken pox		
11.	At risk for contact with AIDS virus		
12.	Has a sexually transmitted disease		
13.	Has any other infectious disease		