NAME: _____

Medical History Please indicate if you have ever had any of these; when:

	Severe headaches		Bowel problems
	Eye/vision glasses/contacts		Colitis
	Ear/hearing problems		Blood in stool
	Dental problems		Mitral valve prolapse
	Last dental appt.		Gall bladder problems
	Thyroid problems		Liver problems
	Rheumatic fever		Hepatitis
	Blood clotting problems		Diabetes/gestation diabetes
	Anemia		Hypoglycemia
	Hemorrhage		Toxemia
	High blood pressure		Bladder/kidney infection
	Varicose veins		Urinary surgery
	Hemorrhoids		Aching joints
	Tuberculosis		Pelvic/back injuries
	Asthma		Seizures
	Allergies		Hospitalizations
	Stomach problems		Surgeries
	Cancer		other

Do you have any allergies to any medications? _____

_____

Gynecological History

Age at first period_____ Cycle length (number of days apart)_____Period duration (number of days)_____
Normal?____Amount of flow: Light moderate heavy
If irregular, describe:_____

When was your last Pap smear?_____Have you ever had an abnormal Pap?_____ If so, when?_____
If so, what abnormality?_____

Please indicate if you have ever had any of the following: When:

	Yeast		Cervicitis
	Trichomonas		Cervical surgery
	Gardneralla		Cervical polyp
	Bacterial vaginosis		Ovarian cyst
	Chlamydia		Fibroids
	Gonorrhea		Endometriosis
	Syphilis		Abnormal bleeding
	PID		Uterine surgery
	Genital sores		Breast lumps
	Herpes: genital___oral____		Breast surgery
	Condyloma (genital warts)		Infertility
	Other		Group B Strep

Are there any particular ethnic, cultural or religious preferences for your care you would like to discuss? _____

_____

Present Pregnancy

Last menstrual period (1st day) _____normal? Yes No
Last normal menstrual period_____
Suspected date of conception_____
Pregnancy test (date)_____Planned pregnancy Yes No

Feelings about pregnancy_____

Father's feelings_____

Do you plan to breastfeed? Yes, experienced Yes, no experience
Undecided No (please circle one)

Most recent birth control used_____
Contraception used in the past: what, when, any problems? _____

_____

Please indicate if you've had any of the following problems during this current pregnancy:

	Nausea		Urinary complaints
	Vomiting		Abdominal/pelvic pain
	Fever		Vaginal bleeding/spotting
	Headaches		Vaginal discharge
	Dizziness		Other bleeding
	Indigestion/heartburn		Varicosities
	Leg cramps		Hemorrhoids
	Rash		Bleeding gums
	Backache		Insomnia
	Swelling(edema)		Loneliness
	Constipation		Depression
	Diarrhea		Family/relationship issues
	Other		Work problems

Please indicate if you have used or been exposed to any of the following during this pregnancy:

	Tobacco		Herbs/supplements
	Alcohol		Fumes/sprays/insecticides
	Caffeine		x-rays
	Marijuana		Ultrasound
	Cocaine		Measles
	Street drugs		Viruses
	Prescriptions drugs		Immunizations
	Non-prescription drugs		Cats
	Vitamins		Other

Planned place of birth:
Home Hospital Other (circle one)

If home, please indicate if you have:
Electricity water telephone (circle)

Please use this space to add any other information you wish to give:

_____
_____
_____
_____
_____
_____
_____
_____
_____