Women's
Medical Associates of Nashville

Established Patient OB Form

Name_____ Age_____ Date of Birth_____ Date_____

PAST MEDICAL HISTORY:

Since your last visit have you been diagnosed with any new HEALTH PROBLEMS? YES NO

If YES, please describe_____

PAST SURGICAL HISTORY:

Have you had any recent SURGERIES? YES NO

If YES, please describe_____

MEDICATIONS:

Please list all PRESCRIBED MEDICATIONS you take on a regular basis. Please note those 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:

Have you developed any new ALLERGIES TO MEDICATIONS? YES NO

If YES, list name of drug and reaction_____

FAMILY HISTORY:

Have there been any CHANGES in your FAMILY HISTORY? YES NO If YES, please note changes:

M=mother **F**=father **S**=sister **B**=brother **MGM**=maternal grandmother **MGF**=maternal grandfather **PGM**=paternal **grandmother PGF**=paternal grandfather

1.	High blood pressure	**M F S B MGM MGF PGM PGF**	
2.	Diabetes	**M F S B MGM MGF PGM PGF**	
3.	Heart disease	**M F S B MGM MGF PGM PGF**	
4.	Breast cancer	**M F S B MGM MGF PGM PGF**	
5.	Ovarian cancer	**M F S B MGM MGF PGM PGF**	
6.	Colon cancer	**M F S B MGM MGF PGM PGF**	
7.	Thyroid disorder	**M F S B MGM MGF PGM PGF**	
8.	Osteoporosis	**M F S B MGM MGF PGM PGF**	
9.	Blood clotting disorder	**M F S B MGM MGF PGM PGF**	
10.	Deep venous thrombosis	**M F S B MGM MGF PGM PGF**	(blood clot deep in leg)
11.	Autoimmune disorder	**M F S B MGM MGF PGM PGF**	(such as lupus, rheumatoid arthritis, etc)
12.	Other_____		

MENSTRUAL HISTORY:

Describe your periods before your pregnancy:

- When was your LAST MENSTRUAL PERIOD? _____
- 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 Quit

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 typed 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

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_____