

# ROSH MATERNAL FETAL MEDICINE

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## OBSTETRIC MEDICAL HISTORY

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

•If you are uncomfortable answering any questions, leave them blank; You can discuss them with your doctor or nurse

## PERSONAL HEALTH HISTORY

1. Are you allergic to any medication? Yes \_\_\_\_ No \_\_\_\_

If yes, please

list: \_\_\_\_\_

2. Please mark any conditions that you have or have had in the past:

Cancer_____	HIV/AIDS_____	Diabetes_____
Epilepsy_____	Thyroid disorder_____	Eating disorder_____
Heart Disease_____	Headaches_____	Depression_____
High Blood Pressure_____	Arthritis or lupus_____	Asthma_____
Kidney disease_____	Frequent infections_____	Anemia_____
Hepatitis_____	Bowel disease_____	Herpes_____
Blood clotting disorder (eg, phlebitis)_____		
Von Willebrand's disease or other bleeding disorders_____		
Sexually transmitted diseases_____		
Recurrent urinary tract infections_____		

Describe if needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please indicate any surgery or hospitalization that you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please describe any health problems or symptoms that you are having at this time:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you or any family member have a history of problems with anesthesia? Yes \_\_\_\_  
No \_\_\_\_ If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? Yes \_\_\_\_ No \_\_\_\_

If yes, how many packs per day? \_\_\_\_\_

If former smoker, when did you quit? \_\_\_\_\_

2. Do you drink alcoholic beverages now or did you before you became pregnant? (1.5 oz spirits = 12 oz beer) Yes \_\_\_\_ No \_\_\_\_

If yes, how often? \_\_\_\_\_

What type of drinks? \_\_\_\_\_

3. Please list any medication taken since your last period, including prescriptions, over the counter drugs, multivitamins, other supplements, and any herbal medicines:

\_\_\_\_\_  
\_\_\_\_\_

4. Please list any illicit or recreational drugs used since your last period (eg, cocaine, marijuana):

\_\_\_\_\_  
\_\_\_\_\_

5. Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)? Yes \_\_\_\_ No \_\_\_\_

6. Are you ever exposed to chemicals or radiation (eg, X-rays)? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

\_\_\_\_\_

7. Are you on a restricted diet? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

\_\_\_\_\_

GYNECOLOGIC HISTORY

1. When was your last Pap test? \_\_\_\_\_

Have you ever had an abnormal Pap test? Yes \_\_\_\_ No \_\_\_\_

If yes, when and how were you treated?

\_\_\_\_\_

What was the diagnosis?

\_\_\_\_\_

2. Have you ever had:

Gonorrhea \_\_\_\_

Chlamydia \_\_\_\_

Pelvic inflammatory disease \_\_\_\_

If yes, when, how and where were you treated?

\_\_\_\_\_

3. Have you ever had herpes? Yes \_\_\_\_ No \_\_\_\_

If yes, how often do you have outbreaks? \_\_\_\_\_

Have you ever had syphilis? Yes \_\_\_\_ No \_\_\_\_

If yes, how, when and where were you treated?

\_\_\_\_\_

\_\_\_\_\_

4. Have you ever used an IUD (intrauterine device) for contraception? Yes \_\_\_\_ No \_\_\_\_

If yes, please indicate when: \_\_\_\_\_

Did you have any problems with the IUD? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

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5. Have you been treated for infertility? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe when and treatment received:

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6. Do you have any other concerns related to your past health history?

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#### FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity? \_\_\_\_\_

What is the ethnicity of the baby's father? \_\_\_\_\_

2. Have you or has the baby's father had a child born with a birth defect? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

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3. Did either you or the baby's father have a birth defect? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe:

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4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, early infant death, deformities, or inherited diseases such as hemophilia, muscular dystrophy or cystic fibrosis):

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How is this child/person related to you? \_\_\_\_\_

5. Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)? Yes \_\_\_\_ No \_\_\_\_

If yes, have either of you had genetic counseling? Yes \_\_\_\_ No \_\_\_\_

If yes, have either of you had chromosomal testing? Yes \_\_\_\_ No \_\_\_\_

Where and what were the results?

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6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, one of these backgrounds:

Eastern European Jewish (Ashkenazi) ancestry? Yes \_\_\_\_ No \_\_\_\_

If yes, have you had Tay-Sachs screening tests? Yes \_\_\_\_ No \_\_\_\_

If yes, have you had a Canavan screening test? Yes \_\_\_\_ No \_\_\_\_

If yes, have you had familial dysautonomia screening? Yes \_\_\_\_ No \_\_\_\_

Date: \_\_\_\_\_ Result: \_\_\_\_\_

African American? Yes \_\_\_\_ No \_\_\_\_

If yes, have you had sickle cell screening? Yes \_\_\_\_ No \_\_\_\_

Date: \_\_\_\_\_ Result: \_\_\_\_\_

European Ancestry & Eastern European Jewish (Ashkenazi) ancestry? Yes \_\_\_\_ No \_\_\_\_

If yes, have you had cystic fibrosis screening? Yes \_\_\_\_ No \_\_\_\_

Date: \_\_\_\_\_ Result: \_\_\_\_\_

Mediterranean ancestry or Southeast Asian ancestry? Yes \_\_\_\_ No \_\_\_\_

If yes, have you had screening for inherited forms of anemia such as thalassemia?

Yes \_\_\_\_ No \_\_\_\_

7. Please list any other concerns you have about birth defects or inherited disorders:

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8. Do you want to have a down syndrome risk assessment? Yes \_\_\_\_ No \_\_\_\_

9. Is the father 50 years or older? Yes \_\_\_\_ No \_\_\_\_

**PSYCHOLOGICAL SCREENING**

1. Do you have any problems (job, transportation etc.) that prevent you from keeping your health care appointments? Yes \_\_\_\_ No \_\_\_\_

2. Do you feel unsafe where you live? Yes \_\_\_\_ No \_\_\_\_

3. Are you exposed to second-hand smoke? Yes \_\_\_\_ No \_\_\_\_

4. In the past two months, have you used drugs or alcohol (including beer, wine & mixed drinks)? Yes \_\_\_\_ No \_\_\_\_

5. In the past year, have you been threatened, hit, slapped, or kicked by anyone you know? Yes \_\_\_\_ No \_\_\_\_

6. Has anyone forced you to perform any sexual act that you did not want to do? Yes \_\_\_\_ No \_\_\_\_

7. On a 1-5 scale (1 being low, 5 being high) how do you rate your stress level? \_\_\_\_

8. How many times have you moved in the past 12 months? \_\_\_\_\_

\*MODIFIED AND REPRINTED WITH PERMISSION FROM FLORIDA'S HEALTHY START PRENATAL RISK SCREENING INSTRUMENT. FLORIDA DEPARTMENT OF HEALTH. DH 3134. SEPTEMBER 1997

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Patient Signature

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Print Name

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Date

