Name:_____ DOB:_____ Age:_____ Today's date:_____

Address:_____ City/State/Zip:_____

Home#:_____ Cell #:_____ Work #:_____

Last Grade Completed: _____ Social Security #:_____-_____-_____

Insurance:_____

Marital Status: M S W D (circle one) Years Married_____

Occupation:_____ Employer:_____

Father of Child:_____ DOB:_____ Age:_____

Last Grade Completed:_____ Employer:_____

Home #:_____ Cell #:_____ Work#:_____

Previous Pregnancies and/or Miscarriages

Date of Delivery	Where Delivered	Weeks Pregnant	Weight Gain	Hours in Labor	Any Problems or Pain Medication	Gender	Weight

Menstrual History

At what age did you start having menstrual periods?_____

How many days between the first days of each month's period?_____

How long do your periods typically last?_____

Did your last menstrual period:

Have (less) (same) (more) than the usual flow? Please circle one

Have (less) (same) (more) than the usual discomfort? Please circle one

Come (earlier) (on time) (later) than usual? Please circle one

What day was your last menstrual period? _____

When was the date of your last Pap Smear and do you have a history of any abnormals?_____

Where was your last Pap Smear performed?_____

Do you and your partner use any of the following types of birth control?:

(Yes) (No) Intrauterine Device (IUD) _____

(Yes) (No) Diaphragm_____

(Yes) (No) Rhythm Method_____

(Yes) (No) Withdrawal Method_____

(Yes) (No) Depo Provera_____

(Yes) (No) Birth control pills (if yes, what is the name)_____

Patient Name:_____ Date:_____

Patient Medical History

What was your weight before becoming pregnant?_____

(Yes) (No) Have you ever had Diabetes?

(Yes) (No) Have you ever had High Blood Pressure?

(Yes) (No) Have you ever had Rheumatic Fever?

(Yes) (No) Have you ever had a heart murmur or bad valve?

(Yes) (No) Have you ever been diagnosed with Asthma?

(Yes) (No) Have you ever had Emphysema?

(Yes) (No) Have you ever had Bronchitis or Pneumonia?

(Yes) (No) Have you ever had Tuberculosis?

(Yes) (No) Do you get short of breath easy, cough, or wheeze frequently?

(Yes) (No) Have you ever had stomach, gallbladder, or bowel problems (diarrhea, constipation, or hemorrhoids?)

(Yes) (No) Have you ever had bleeding from the bowels?

(Yes) (No) Do you ever have trouble with heartburn?

(Yes) (No) Have you ever had Hepatitis, Jaundice, or Cirrhosis?

(Yes) (No) Have you ever had a bladder or kidney infection (or kidney stones?)

(Yes) (No) Does it hurt to urinate or have you ever had blood in your urine?

(Yes) (No) Have you ever had cysts or tumors of the uterus or ovaries?

(Yes) (No) Do you have any unusual vaginal odors or discharge?

(Yes) (No) Do you have any painful periods or pain with intercourse?

(Yes) (No) Have you ever had an infection of the fallopian tubes, uterus, or ovaries?

(Yes) (No) Have you ever had seizures?

(Yes) (No) Have you ever had frequent headaches or migraines?

(Yes) (No) Have you ever fainted or been knocked unconscious?

(Yes) (No) Have you ever had any thyroid problems?

(Yes) (No) Have you ever had Depression or suicidal tendencies?

(Yes) (No) Have you ever received or wanted Psychological Counseling or treatment for “nerves”?

(Yes) (No) Have you ever had Group B Strep Infection?

(Yes) (No) Have you ever had any of the following: Syphilis (bad blood), Gonorrhea (clap), Chlamydia, Venereal Warts (HPV), AIDS, Herpes? If yes, please circle which one/s

(Yes) (No) Have you ever had any blood clots in the lungs or legs?

(Yes) (No) Have you ever been abused physically or sexually?

(Yes) (No) Have you ever gone longer than a year trying to conceive without a pregnancy?

(Yes) (No) Have you ever received a blood transfusion?

(Yes) (No) Have you ever used any form of Nicotine?

(Yes) (No) Have you or do you consume Alcohol?

Name:_____ Today's Date:_____

(Yes) (No) Have you or do you use any recreational drugs?

(Yes) (No) Have you ever had Chickenpox or received the Varicella Vaccine?

If you answered yes to any of the above questions, please explain in this area:

_____

_____

_____

_____

_____

Do you have any allergies to any medications or environmental factors?

Please list:_____

Are you currently taking any medications or vitamins?

Please list:_____

Please list any additional medications you have taken in the last 6 months:

_____

Have you ever had any surgeries or procedures performed? Please list:

_____

(Yes) (No) Have you ever been hospitalized?

If yes, please list year and reason:_____

(Yes) (No) Are you happy about this pregnancy?

(Yes) (No) Is your partner happy about this pregnancy?

(Yes) (No) Does anyone in your household smoke?

(Yes) (No) Do you have cats?

When was your last Tetanus Booster? _____

How many servings of Milk do you drink each day?_____

How many servings of meat do you eat each day?_____

How much pop, tea, or coffee do you drink each day?_____

Do you exercise regularly and if so, what kind of exercise?_____

(Yes) (No) Do you intend to breastfeed. If your answer is no, why?_____

How often do you eat "junk food" (chips, cookies, cake, candy, etc?)_____

Do you take a regular vitamin, herb al, or health food supplement?_____

Do you or ANYONE in your household work at East Penn Manufacturing?_____

Name:_____ Today's Date:_____

Family History

(Yes) (No) Has anyone in your family ever had a baby with a birth defect?

(Yes) (No) Have you or any family member ever had a stillborn infant?

(Yes) (No) Are you and the father's family related by blood?

Has anyone ever had any of the following diseases (Please circle if any are applicable and write who it applies to next to the diagnosis):

Anemia_____

Thalasemia_____

Mental Retardation or Down Syndrome_____

Hemophilia (bleeding disorder)_____

Cystic Fibrosis_____

Muscular Dystrophy_____

Meningomyelocele (open spine)_____

Chromosomal abnormality_____

Sickle Cell Disease_____

Twin or Triplet pregnancy/delivery_____

If you have any additional information, special concerns, or questions, please use the remaining space to communicate: