

Elite Obstetrics & Gynecology

Specializing in: Minimally Invasive Laparoscopic & Robotic Surgery • VIP Obstetrical Packages



MEDICAL DIRECTOR: Dr. Lanalee Araba Sam, BSc., M.D., F.A.C.O.G
Diplomate American Board of Obstetrics & Gynecology

OBSTETRIC MEDICAL HISTORY

Patient Name: _____ Date from completed: _____

*IF you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. YES NO Are you allergic to any medication? If yes, please list: _____

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

- | | | |
|---|---|--|
| <input type="radio"/> Cancer | <input type="radio"/> HIV/AIDS | <input type="radio"/> Diabetes |
| <input type="radio"/> Epilepsy | <input type="radio"/> Thyroid disorder | <input type="radio"/> Eating disorders |
| <input type="radio"/> Heart disease | <input type="radio"/> Headaches | <input type="radio"/> Depression |
| <input type="radio"/> High blood pressure | <input type="radio"/> Arthritis or lupus | <input type="radio"/> Asthma |
| <input type="radio"/> Kidney disease | <input type="radio"/> frequent infections | <input type="radio"/> Anemia |
| <input type="radio"/> Hepatitis | <input type="radio"/> Bowel disease | <input type="radio"/> Herpes |
| <input type="radio"/> Von Willebrand's disease or
other bleeding disorders | <input type="radio"/> Sexually transmitted disease | <input type="radio"/> Recurrent Urinary tract infections |
| | <input type="radio"/> Blood clotting disorder (eg, phlebitis) | |

Describe, if needed: _____

3. Please indicate any surgery that you have had: _____

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

5. YES NO Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. YES NO Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)?

If yes, please describe: _____

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EXPOSURE AFFECTING HEALTH

1. YES NO Do you smoke cigarettes? If yes, how many packs per day? _____

2. YES NO Do you drink alcoholic beverages? If yes, how often? _____

What types of drinks? _____

3. Please list any medications 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. YES NO 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)?

6. YES NO Are you ever exposed to chemicals or radiation (eg, X-ray)? If yes, please indicate:

7. YES NO Are you on a restricted diet? If yes, please describe:

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GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____

YES NO Have you ever had an abnormal Pap test? If yes, how and where you treated?

What was the diagnosis? _____

2. YES NO Have you ever had gonorrhea,
 YES NO Chlamydia, or
 YES NO pelvic inflammatory disease?

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

3. YES NO Have you ever had herpes? If yes, how often do you have outbreaks?

YES NO Have you ever had syphilis? If yes, please describe:

4. YES NO Have you ever used an IUD (intrauterine device) for contraception? If yes, please indicate when:

YES NO Did you have any problems with the IUD? If yes, please describe:

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5. YES NO Have you been treated for infertility? If yes, please describe when and treatment received:

6. YES NO Do you have any other concerns related to your past health history? If yes, please list:

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FAMILY HISTORY & GENETIC SCREENING

1. YES NO Have you or has the baby's father had a child born with a birth defect? If yes, please describe:

2. YES NO Did either you or the baby's father have a birth defect? If yes, please describe:

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

How is this child/person related to you? _____

4. YES NO Do you or does the baby's father have a history of pregnancy losses (miscarriage or stillborn)?

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

YES NO Eastern Europe Jewish ancestry

If yes, have you had Tay-Sachs screening test? YES NO

If yes, have you had a Canavan screening test? YES NO

Date _____ Result _____

YES NO African American

If yes, have you had sickle cell screening? YES NO

Date _____ Result _____

YES NO European Ancestry

If yes, have you had cystic fibrosis screening? YES NO

Date _____ Result _____

YES NO Mediterranean Ancestry or Southeast Asian Ancestry

If yes, have you had screening for inherited forms of anemia such as thalassemia? YES NO

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

7. YES NO Will you be 35 years or older at the time the baby is born?

8. YES NO Will the father be 50 years or older?

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PSYCHOSOCIAL SCREENING

- YES NO Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
- YES NO Do you feel unsafe where you live?
- YES NO In the past 2 months, have you used any form of tobacco?
- YES NO In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
- YES NO In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
- YES NO Has anyone forced you to perform any sexual act that you did not want to do?
- On a scale, how do you rate your current stress level? LOW 1 2 3 4 5 HIGH
- How many times have you moved in the past 12 months? _____
- If you could change the timing of this pregnancy, would you want it
 Earlier Later Not at all No change

Patient signature _____

Print Name _____ Date _____