Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History - OB

Name ______________________________ Birthdate________ Age _____ Date___________

Current Medications (Prescription, over the counter, herbal)	Prescribing Doctor	Dose	Instructions	Reason Used

Allergies to medications/food/environment	Reaction

Pharmacy: ____

Gynecologic Health History

LMP (first day of your last period): ___________________ Definite / Unknown date / Approximate date

Were your periods regular before pregnancy? Yes / No How often? ______________________________

Were you on birth control at the time of conception? Yes / No Explain: ______________________________

What age were you when you started your first period? ___________

Was this a planned pregnancy? Yes / No

Was this a result of In Vitro Fertilization? Yes / No

If yes: donor sperm / donor egg

What was the date of conception? ______________________________

Total number of pregnancies

Full Term	Premature	Cesarean Section	Vaginal Delivery	Living	Multiple Births	Abortion	Miscarriage	Ectopic

Pregnancy Details

Preg #	Sex	Month/Year of Delivery	Number of Weeks	Baby's Weight	Hours of Labor	Delivery Type	OB/Neonatal Problems	Delivery Doctor

Symptoms since your last period? ____

____

What medications have you taken since your last period? ____

____

Medical History

Have you had or have any of the following conditions:

Disease/Condition	Yes	No	Onset Date	Treatment
Diabetes				
Hypertension				
Heart Disease				
Autoimmune Disorder				
Kidney Disease/UTI				
Neurologic/Epilepsy				
Psychiatric				
Depression/Postpartum Depression				
Hepatitis/Liver Disease				
Varicosities/Phlebitis/ Blood Clot				
Thyroid Dysfunction				
Trauma/Violence				
History of Blood Transfusions				
Rh Sensitized				
Pulmonary (TB, Asthma)				
Seasonal Allergies				
Drug/latex allergies/ reactions				
Breast Problems				
GYN Surgery				
Operations/Hospitalization				
Anesthetic Complications				
History Abnormal Pap				
Uterine Anomaly/DES				
Infertility				
ART Treatment				
Relevant Family History				
Received HPV Vaccine				

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Infection History

Have you ever been diagnosed with or exposed to any of the following conditions:

Condition	Yes	No	Exposure/Onset Date	Treatment
TB				
Rash/viral illness				
Hepatitis B or C				
Chicken pox				
Gonorrhea				
Chlamydia				
HPV/Warts				
HIV				
Syphilis				
Genital herpes				
Other:				

Medical/Surgical History

Include injuries and conditions requiring medications i.e. high blood pressure, diabetes, seizures, etc.

Condition/Disease	Date	Treatment

Do you desire sterilization after pregnancy? Yes / No

Will you be: breast feeding / bottle feeding / both

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Yes	No	Relation	Family Member's 1st Name	Age of Onset	Age of Death	Cause of Death (Yes or No)
Cancer of Breast							
Cancer of Ovary							
Cancer of Uterus							
Cancer of Cervix							
Cancer of Colon							
Diabetes							
Tuberculosis							
Heart Disease							
High Blood Pressure							
Blood Clot/PE							
Other: (enter below)							

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Social History

Marital status ____

Do you have an Advanced Directive? Yes / No

Primary language spoken _________________________ Race _________________________

Do you smoke cigarettes? Yes / No If yes, pks/day _______ How many years _______

Do you use e-cigarretes or vape? Yes / No If yes, with nicotine? Yes / No How many mg? _______ How often? ______________________________

Do you drink alcohol? Yes / No If yes, what kind? ____________________ How often? ____________________ Amount __________________________

Do you consume caffeine? Yes / No If yes, what kind? ____________________ Amount ____________________

Do you use medical marijuana? Yes / No If yes, what kind? ___________________ How often? ___________________ Amount ___________________

Do you use recreational drugs? Yes / No If yes, what kind? ___________________

(We do recommend that you discontinue the use of nicotine, alcohol, caffeine, medical marijuana, and recreational drugs)

Do you exercise? Never / Occasionally / Daily / 2-3 times per week / 4 or more times per week

How many sexual partners do you have? None / 1 / 2-5 / 5+

Have you been exposed to sexual or physical violence or abuse? Yes / No

Genetic History

Includes patient, baby's father, or anyone in either family

History	Yes	No	Mother (patient)	Baby's Father	Other Relative
1. Patient's age 35 or older at delivery					
2. Thalassemia					
3. Neural tube defect					
4. Congenital heart defect					
5. Down syndrome					
6. Tay-sachs					
7. Canavan disease					
8. Familial dysautonomia					
9. Sickle cell disease or trait					
10. Hemophilia or other blood disorders					
11. Muscular dystrophy					
12. Cystic fibrosis					
13. Huntington's chorea					
14. Mental retardation/ Autism					
15. Other inherited genetic or chromosomal disorder					
16. Metabolic disorder (e.g. PKU, Type 1 diabetes)					
17. Patient or baby's father had a child with birth defects not listed above					
18. Recurrent pregnancy loss or stillbirth					
19. Medications (supplements, vitamins, herbs or OTC drug/illicit/recreational drugs/ alcohol since Last Menstrual Period?					