The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Patient Addressograph

OBSTETRIC MEDICAL HISTORY

Name:

LAST FIRST MIDDLE

Date Form 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 Have you ever had an allergic reaction to a medication or vaccine component?

If yes, please list: _____

Any other allergies or reactions? _____

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

- ☐ Epilepsy
- ☐ Headaches
- ☐ Thyroid Disorder
- ☐ Breast Disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Anemia
- ☐ von Willebrand disease or other bleeding disorders
- ☐ Blood Clotting Disorder (eg, Phlebitis/Thrombophilia)
- ☐ Blood Transfusion
- ☐ Gastrointestinal Illness
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Recurrent Urinary Tract Infections
- ☐ Gestational Diabetes
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Arthritis or Lupus
- ☐ Skin Disorders
- ☐ Prior Preterm Birth
- ☐ Group B Streptococcus In Prior Pregnancy
- ☐ Herpes
- ☐ Sexually Transmitted Infections
- ☐ HIV/AIDS
- ☐ Frequent Infections
- ☐ Psychiatric Illness
- ☐ Depression/Postpartum Depression
- ☐ Eating Disorder
- ☐ Other: _____

Describe, if needed: _____

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

4. Please describe any health problems or symptoms that you 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 objections to any form of medical treatment (eg, blood transfusion)?

If yes, please describe: _____

Exposures Affecting Health

1. ☐ Yes ☐ No Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped?

   If yes, how many packs per day? _____ If former smoker/user, when did you quit? _____

2. ☐ Yes ☐ No Do you drink alcoholic beverages now or did you before you became pregnant?

   If yes, please indicate number of drinks per week: _____

   What type 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. ☐ Yes ☐ No Have you used any street drugs since your last menstrual period (eg, cocaine, marijuana, opioids)?

   If yes, please indicate number of uses per week: _____

   What type of drugs? _____

5. ☐ Yes ☐ No Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?

6. ☐ Yes ☐ No Have you been exposed to chemicals (eg, pesticides, lead, hazardous material/agents) or radiation (eg, X-rays) since you became pregnant?

   If yes, please describe: _____

7. ☐ Yes ☐ No Are you on a restricted diet?

   If yes, please describe: _____

Gynecologic Health History

1. When was your last Pap test? _____

   ☐ Yes ☐ No Have you received all three doses of the HPV vaccine?

   ☐ Yes ☐ No Have you ever had an abnormal pap test?

   If yes, when and how were you treated? _____

   What was the diagnosis? _____

   ☐ Yes ☐ No Have you ever had HPV?

2. ☐ Yes ☐ No Have you ever had ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease

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

3. ☐ Yes ☐ No Have you ever had herpes?

   If yes, where do you have outbreaks? _____

   If yes, how often do you have outbreaks? _____

   ☐ Yes ☐ No Have you ever had syphilis?

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

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

   If yes, please indicate when: _____

   ☐ Yes ☐ No Did you have any problem with the IUD?

   If yes, please describe: _____

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: _____

Family History & Genetic Screening

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

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

   If yes, please describe: _____

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

   If yes, please describe: _____

4. Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):

   _____

   _____

   How is this child/person related to you? _____

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

   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? _____

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, of one of these backgrounds:

   ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) Ancestry

   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: _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell 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

   ☐ Yes ☐ No French Canadian or Cajun Ancestry

   If yes, have you had Tay–Sachs screening tests? ☐ Yes ☐ No

7. ☐ Yes ☐ No Have you had cystic fibrosis screening?

8. ☐ Yes ☐ No Have you had any other genetic carrier screening, such as an expanded carrier screening?

   Screening: _____ Date: _____ /_____ /_____ Result: _____

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

   _____

   _____

   _____

10. ☐ Yes ☐ No Do you want a test that will tell you about your risk to have a baby with Down syndrome?

11. ☐ Yes ☐ No Is the father 45 years or older?

Psychosocial Screening*

1. ☐ Yes ☐ No Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No Do you feel unsafe where you live?
3. ☐ Yes ☐ No Are you exposed to second-hand smoke? ☐ Yes ☐ No In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped?
4. ☐ Yes ☐ No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No Has anyone forced you to perform any sexual act that you did not want to do?
7. On a 1–5 scale, how do you rate your current stress level? Low 1☐ 2☐ 3☐ 4☐ 5☐ High
8. How many times have you moved in the past 12 months? _____
9. If you could change the timing of this pregnancy, would you want it ☐ earlier ☐ later ☐ not at all/NA

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____
PATIENT SIGNATURE

_____
PRINT NAME

_____
DATE

Notes