Stanford HEALTH CARE

ValleyCare Physicians Associates

Your name:_____ Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

## *MENSTRUAL HISTORY*

WHEN WAS YOUR LAST MENSTRUAL PERIOD (LMP) :_____ WAS IT NORMAL IN DURATION? ___YES ___NO
DO YOU HAVE MONTHLY PERIODS? ____YES ____NO IF NO, HOW OFTEN DO YOU HAVE A PERIOD:_____
AT WHAT AGE DID YOU HAVE YOUR FIRST PERIOD:_____
ARE YOU USING CONTRACEPTION CURRENTLY (PILLS, RING, INJECTION, PATCH)? _____YES _____NO

## *PAST PREGNANCY HISTORY*

| TOTAL PREGNANCIES | FULL TERM | PREMATURE | ABORTIONS INDUCED | ABORTIONS SPONTANEOUS | ECTOPICS | MULTIPLE BIRTHS | LIVING |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## *PAST PREGNANCY ( LAST SIX)*

| DATE M/D/Y | GA WEEKS | LENGTH OF LABOR | BIRTH WEIGHT | SEX | TYPE OF DELIVERY | PLACE OF DELIVERY | COMPLICATIONS |
|---|---|---|---|---|---|---|---|
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## *MEDICAL HISTORY*

| | - NEG + POS | DATE & TREATMENT | | - NEG + POS | DATE & TREATMENT |
|---|---|---|---|---|---|
| DIABETES | | | D (RH) SENSITIZED | | |
| HYPERTENSION | | | PULMONARY (TB, ASTHMA) | | |
| HEART DISEASE | | | SEASONAL ALLERGIES | | |
| AUTOIMMUNE DISORDER | | | DRUG / LATEX ALLERGIES / REACTIONS | | |
| KIDNEY DISEASE / UTI | | | BREAST | | |
| NEUROLOGIC/EPILEPSY | | | GYN SURGERY | | |
| PSYCHIATRIC | | | OPERATIONS/HOSPITALIZATIONS | | |
| DEPRESSION/POST PARTUM DEPRESSION | | | ANESTHETIC COMPLICATIONS | | |
| HEPATITIS / LIVER DISEASE | | | HISTORY OF ABNORMAL PAP | | |
| VARICOSITIES / PHLEBITIS | | | UTERINE ANOMALY/DES | | |
| THYROID DYSFUNCTION | | | INFERTILITY | | |
| TRAUMA / VIOLENCE | | | ART TREATMENT | | |
| HISTORY OF BLOOD TRANSFUSIONS | | | RELEVANT FAMILY HISTORY | | |
| | | | | | |

| | TOBACCO | ALCOHOL | ILLICIT/RECREATIONAL DRUGS |
|---|---|---|---|
| PPD / AMT PER DAY - PRE-PREGNANT | | | |
| PPD / AMT PER DAY - PREGNANT | | | |
| # YEARS USE | | | |

## *INFECTION HISTORY*

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB? | | | HISTORY OF HEPATITIS B OR C? | | |
| | | | HISTORY OF STI? | | |
| PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES? | | | HISTORY OF HPV? | | |
| | | | HISTORY OF GONORRHEA? | | |
| RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD? | | | HISTORY OF HIV? | | |
| | | | HISTORY OF CHLAMYDIA? | | |
| | | | HISTORY OF SYPHILIS? | | |

## *PAST SURGERIES*

| DATE MONTH | DATE YEAR | SURGERY PERFORMED | DATE MONTH | DATE YEAR | SURGERY PERFORMED |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## *ALLERGIES*

ARE YOU ALLERGIC TO LATEX? _____YES _____NO

| MEDICATION | REACTION | MEDICATION | REACTION |
|---|---|---|---|
| | | | |
| | | | |

## *FAMILY HISTORY*

| FAMILY MEMBER | DISEASE | FAMILY MEMBER | DISEASE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## *CURRENT PREGNANCY*

WHAT SYMPTOMS OF PREGNANCY HAVE YOU EXPERIENCED SINCE YOUR LAST MENSTRUAL PERIOD?
____NAUSEA/VOMITING ____BREAST TENDERNESS ____VAGINAL BLEEDING OTHER:_____

WHAT MEDICATIONS HAVE YOU TAKEN SINCE YOUR LAST MENSTRUAL PERIOD?

| NAME OF MEDICATION AND DOSAGE | NAME OF MEDICATION AND DOSAGE |
|---|---|
| | |
| | |

## *GENETIC SCREENING/TERATOLOGY COUNSELING*

| | YES | NO | MOTHER | FATHER (BABY'S) | RELATIVE |
|---|---|---|---|---|---|
| PATIENT'S AGE 35 YEARS OR OLDER AT ESTIMATED DATE OF DELIVERY? | | | | | |
| **PATIENT, BABY'S FATHER OR FAMILY MEMBER DIAGNOSED WITH THE FOLLOWING:** | | | | | |
| THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN OR ASIAN BACKGROUND) MCV<80 ? | | | | | |
| NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANACEPHALY) ? | | | | | |
| CONGENITAL HEART DEFECT ? | | | | | |

| *CONTINUED… PATIENT, BABY FATHER OR FAMILY MEMBER DIAGNOSED WITH:* | YES | NO | MOTHER | FATHER (BABY'S) | RELATIVE |
|---|---|---|---|---|---|
| DOWN SYNDROME ? | | | | | |
| TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN) ? | | | | | |
| CANAVAN DISEASE (ASHKENAZI JEWISH) ? | | | | | |
| FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH) ? | | | | | |
| SICKLE CELL DISEASE OR TRAIT (AFRICAN) ? | | | | | |
| HEMOPHILIA OR OTHER BLOOD DISORDERS ? | | | | | |
| MUSCULAR DYSTROPHY ? | | | | | |
| CYSTIC FIBROSIS ? | | | | | |
| HUNTINGTON'S CHOREA ? | | | | | |
| MENTAL RETARDATION / AUTISM ? | | | | | |
| OTHER INHERITED GENETIC OR CHOROMOSOMAL DISORDER ? | | | | | |
| MATERNAL METABOLIC DISORDER (E.G. TYPE 1 DIABETES, PKU) ? | | | | | |
| PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECT NOT LISTED ABOVE ? | | | | | |
| RECURRENT PREGNANCY LOSS OR A STILLBIRTH ? | | | | | |
| TAKEN ANY OF FOLLOWING SINCE LMP: SUPPLEMENTS, VITAMINS, HERB OR OTC DRUGS/ILLICIT/RECREATIONAL DRUGS? | | | IF YES, PLEASE LIST: | | |

PATIENT'S PRIMARY LANGUAGE: _____ EDUCATION (LAST GRADE COMPLETED): _____

LANGUAGE AT HOME: _____ RELIGION: _____

PATIENT'S BIRTHPLACE: _____ PATIENT'S OCCUPATION: _____

PATIENT'S ETHNICITY: _____ EMPLOYER: _____

BABY FATHER'S NAME: _____ PHONE NUMBER: _____

BABY FATHER'S ETHNICITY: _____

SUPPORT PERSON NAME: _____ PHONE NUMBER: _____

BABY'S PEDIATRICIAN:

WHAT WAS YOUR LAST WEIGHT (PRE-PREGNANCY):_____ WHAT IS YOUR HEIGHT: _____

DO YOU USE CAFFEINE? ____YES ___NO AMOUNT DAILY _____ TYPE _____COFFEE _____TEA _____SODA ____CHOCOLATE

ARE YOU PLANNING TO PARTICIPATE IN PRENATAL CLASSES? ____YES _____NO

ARE YOU PLANNING TO FEED _____BREAST _____BOTTLE _____BOTH

DOES THE PATIENT AGREE TO BLOOD TRANSFUSIONS? ____YES _____NO

DOES THE PATIENT DESIRE PERMANENT STERILIZATION? ____YES _____NO

ARE YOU ENROLLED IN WIC PRENATAL CARE PROGRAM? ____YES _____NO

WHAT IS YOUR ACTIVITY LEVEL _____
EXERCISE FREQUENCY _____

ARE YOU A HEALTH CLUB MEMBER? ___NOW ___PREVIOUSLY ___NEVER
TYPE OF EXERCISE _____

ARE THERE FIREARMS IN THE HOME? ___ YES ____NO
DO YOU USE YOUR SEATBELT REGULARLY? ____YES ____NO
ARE THERE CATS IN THE HOME? ____YES ____NO

ARE THERE SMOKE DECTECTORS IN THE HOME? ____YES ____NO
ARE THERE CARBON MONOXIDE DETECTORS IN THE HOME? ____YES ____NO
IS THERE RADON IN THE HOME? ___YES ___NO ___TREATED ___UNTESTED

IS THERE PASSIVE SMOKE EXPOSURE? _____YES _____NO