Tulsa Women's Health Care

Name:_____ Doctor: _____

DOB: _____ Ethnicity:_____

May we leave a detailed message on voicemail? **YES/NO**

What was your baseline weight? (right before you got pregnant)_____ lbs.
What is your current height?_____ Feet _____. Inches

What was the first day of your last menstrual period? (if unknown, give your best guess) _____/_____/_____

How old were you when you first started your period? _____ years old.

Are your periods regular? _____

If so, how many days does your cycle normally run? _____days

How long do you normally bleed with your periods? _____ days

How much did you weigh at birth? _____ lbs _____oz
How much did your partner weigh at birth? _____ lbs_____oz

Do you have any history of traumatic births in your family? _____

If so, please describe: _____

Please list all previous pregnancies, including any miscarriages and elective abortions:

DOB	Miscarriage or abortion	Gestational age	Vaginal or cesarean	Length or labor (hrs)	Hospital	Sex and weight of baby	Child's name

Were there any complications with any of your previous pregnancies or deliveries? If so, please describe:_____

_____

_____

Please indicate if you have or have had any of the following medical conditions.

_____ allergic rhinitis
_____ anemia or other blood disorders
_____ asthma or other pulmonary disorders
_____ autoimmune disorder
_____ breast disorder
_____ infertility
_____ liver disease
_____ neurologic disorder
_____ renal disease
_____ (Rh) Sensitized
_____ thyroid disorder
_____ depression
_____ psychiatric disorder
_____ diabetes
_____ heart disease
_____ hypertension (high blood pressure)
_____trauma history
_____ uterine abnormalities
_____ varicosities/ DVT (blood clots)
_____ anesthetic complications
_____ other family history
_____ other

If you checked yes to any of the above, please explain:_____
_____

Have you ever had a blood transfusion? YES/NO
If so, when? _____
When was your last pap smear? _____
Have you ever had an abnormal pap smear? YES/NO
If so, when? _____
Have you ever had any surgeries on your cervix, or have you every had to have any part of your cervix frozen?
YES/NO _____

Since finding out you were pregnant, have you used any:
Alcohol YES/NO
if so, how many drinks per day? _____

Tobacco YES/NO
if so, how many per day? _____

Drugs YES/NO
if so, what kind? _____
if so, how much per day? _____

Have you ever had surgeries or hospitalizations (other than childbirth?)

Surgery or Hospitalization	When? (year)	Comment

Does anyone in your family or your partner's family have any history of any genetic abnormalities?

_____ Neural Tube Defect (Spina Bifida, Anencephaly)
_____Trisomy 21 (Downs Syndrome)
_____ Congenital Heart Defect
_____ Cystic Fibrosis
_____ Tay-Sachs (Jewish, Cajun, French Canadian)
_____ Thalassemia (Italian, Greek, Mediterranean, Asian)
_____ Canavan Syndrome
_____ Hemophilia Or Hematologic Disease
_____ Huntington's Chorea
_____ Autism
- if so was this person tested for Fragile X? _____
_____ Mental Retardation
- if so was this person tested for Fragile X? _____
_____ Muscular Dystrophy
_____ Sickle Cell Disease or Trait (African)
_____ Other Inherited Genetic or Chromosomal Disorder
_____ Maternal Metabolic Disorder (type 1 diabetes, PKU)
_____ Recurrent Pregnancy Loss, or a Stillbirth
_____ Other Birth Defects
_____ Other Genetic Screening

If you answered yes to any of the above, please explain who has the disorder: _____
_____

Have you or your partner ever had:
_____ HIV or AIDS
_____ Genital Herpes
_____ Any other STDs

If yes, please explain who had the disease and if treatment was received. _____
_____

Have you ever been exposed to TB (tuberculosis)? _____
If so, please explain if you had negative test, or received treatment _____

Have you had any kind of rash or viral illness since your last menstrual period? _____
If so, please explain _____

Have you ever had chicken pox? _____
Or have you received the vaccine? _____

Have you had any other significant exposure or history of infection? _____
If so, please explain_____

Do you feel safe at home? YES/NO

Please list any and all medication you are currently taking.

Medication	Dosage

Please list all medication that you are allergic to

Medication	Reaction

Preferred pharmacy name and location _____