

# Fertility & Midwifery Care Center



G# \_\_\_\_\_

## Patient Health History

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Referred By: \_\_\_\_\_

Reason for visit: \_\_\_\_\_ Date: \_\_\_\_\_

## Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Hypertension			
Anemia				Infertility			
Anesthesia Complication				Kidney Stone			
Anxiety				Liver Disease			
Asthma				Lupus			
Blood Clots in Leg or Lungs				Migraine			
Blood Transfusion				Miscarriage			
Breast Disorder				MTHFR			
Cancer of the Breast				Mitral Valve Prolapse			
Cancer, other				PAI-1			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Depression				PCOS			
Diabetes				Seizures/Convulsions			
Endometriosis				Sexually Transmitted Diseases, STD's			
Epilepsy				Stroke			
Factor 5				Thyroid Disorder			
Fibromyalgia				Tuberculosis			
Heart Murmur				Ulcer			
Herpes				Von Willebrand's Disease			
Date of Last Pap Smear: / /	Normal	Abnormal		Date of Last Mammogram: / /	Normal	Abnormal	
Date of Last Dexa Scan: / /	Normal	Abnormal		Date of Last Colonoscopy: / /	Normal	Abnormal	
Other:							
<b>Willing to receive blood products, if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>							

## Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

## Medications

(Include prescriptions, over the counter, herbals & vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		

SEE BACK



### Medication Allergies

Do you have any drug allergies?  NO  YES (if yes, please list below)

MEDICATION	REACTION
1)	
2)	
3)	

### Family Medical History

(Do any of your children, siblings, or parents have any of the following?)

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp – anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer, Other			Thyroid Disorder		

### Genetic History / Screening

(Self, partner, or other family member)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats – do you have exposure?			Diabetes – self only		
Chickenpox			Down Syndrome		
Congenital Heart Defect			Infertility		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		

### REPRODUCTIVE HISTORY

Age of first menses:	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (circle):    Light            Medium            Heavy
Number of Tampons per day:	Number of Pads per day:
Last Menstrual Period (date):        /        /	Certain of LMP date? (circle)    YES            NO
Menopause Status (circle):    Pre        Peri        Post	Age at Menopause:
Method of Family Planning:	Sexually Active: (circle)    YES            NO
Bleeding between periods: (circle)    YES            NO	Pain with menses: (circle)    YES            NO

### Pregnancy History

Total Pregnancies: _____ / Full Term: _____ / Preterm: _____ / Miscarriage: _____ / Abortion: _____ / Ectopic: _____ / Multiple: _____ / Living: _____								
DATE	GESTATIONAL AGE	HOURS IN LABOR	BIRTH WEIGHT	GENDER	TYPE OF DELIVERY	ANESTHESIA	COMMENTS/ COMPLICATIONS	FACILITY/ PROVIDER

### Social History

Marital Status (circle):    Single    Married    Widowed    Divorced    Spouse/Partner Name: _____
Occupation: _____
Religious Preference: _____
Alcohol:            Never            Current            Former            Amount per week
Drugs:    _____ Never    _____ Current    _____ Former    _____ Type
Smoking: _____ Never    _____ Current    _____ Former    _____ Amount per day
Amount of Exercise?    Active            Heavy            Medium            Minimal            None (Sedentary)