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/Renal disease			
Anxiety				Liver Disease			
Asthma				Lupus			
Blood Clots in Leg or Lungs				Migraine			
Blood Transfusion				Miscarriage			
Breast Disorder				M THFR			
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				Uterine Fibroids/polyps			
Other:				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

Will you receive blood products in a life-threatening emergency? ☐ Yes ☐ No

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 PROVIDER
1)	
2)	
3)	
4)	
5)	

SEE BACK

Allergies

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

MEDICATION	REACTION
1)	
2)	
3)	
Are you allergic to Penicillin? ○ NO ○ YES if yes, please list reaction→	

Family Medical History

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

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHP
Pregnancy Loss			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer (specify)			Hypertension		
Alzheimer's			Osteoporosis		
Thyroid Disorder			Preeclampsia		
MTHFR/FACTOR V/PAI			Stroke		

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:	Frequency of menses:
Menses duration (Number of days of bleeding):	Flow (circle): Light Medium Heavy
Number of Tampons/pads per day:	Number of menstrual cup changes?
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	HOW FAR ALONG WERE YOU?	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:_______________________
Your Occupation:
Religious Preference:
Do you feel safe in your current relationship?
Alcohol: Never Current Former Amount per week:
Drugs: ________Never ________Current _________Former_______________Type:
Cigarettes/Vape/Marijuana (circle): Never_____Current______Former________________Amount per day:
Amount of Exercise? Active Heavy Medium Minimal None (Sedentary)