Name_____ Date of birth_____Date_____

Referring physician:_____ OR Phone Book [] Internet [] Friend [] Returning patient [] Other []

Please answer the following questions regarding your health history.

Allergy Please list all medications which have caused an allergic reaction or any other unpleasant side effects. Include any reactions to antibiotics, pain medications, aspirin, latex, eggs, peanuts, and soy. Describe what the reaction was, if possible

Medications Please list all medications you are taking. Include prescription drugs, over-the-counter drugs, and herbs. Indicate what each one is for. Include any illicit substances used in the last 2 weeks.

Medical History If you have had any health problems in the past or are now under a physician's care for any health problems in addition to the pregnancy, please describe. (Heart disease, murmur, irregular heart beat, mitral valve prolase, high blood pressure, blood clot in a major vein, blood clotting disorder, thrombophilia, anemia, asthma, other respiratory problem, ulcers, inflammatory bowel disease, kidney disorder, joint or bone problems, headaches, seizure disorder, lupus, diabetes, thyroid disorders, pituitary tumor, cancer)

Gyn Have you ever had uterine fibroids, ovarian cysts, endometriosis, infertility, very heavy or very irregular menstrual periods? Uterine abnormality? Any other female problems.

Pap smear Have you ever had an abnormal Pap? If so how and when was it treated (freezing, laser, LEEP, cone)

Surgical History Have you ever had any surgical procedure? If so, please provide details. Please include Cesarean sections, laparoscopy, myomectomy (to remove uterine fibroids).

Anesthesia Have you ever had anesthesia before? If so, please describe any complications or unpleasant reactions.

Family History Has anyone in your immediate family (mother, father, sister, brother) who was less than 50 years old had a heart attack, stroke, blood clot in the leg or lung, a blood clotting disorder, or had breast cancer? If so, please provide details.

Tobacco If you smoke, please indicate how much

Alcohol Alcohol and most illicit substances can affect your tolerance to anesthetics. The following will be kept confidential. Please list any present or past use of large amounts of alcohol, cocaine, amphetamine, other forms of speed, narcotics, marijuana, tranquilizers, or hallucinogens.

Mental Health Do you have or had in the past any depression, anxiety, panic attacks, eating disorder, or other mental health problem?

STDs Have you ever had herpes, HPV, Chlamydia, hepatitis or any other sexually transmitted infections?

Pregnancy History Please list all previous pregnancies and indicate how many were full term vaginal deliveries, C-sections, elective abortions, spontaneous abortions, aborted because of a complication with the pregnancy, ectopic pregnancy. If this is your first time being pregnant please write "none"

This pregnancy The first day of your last normal period of if known, the date of conception? If you have been examined or had ultrasound done, please indicate where and what the results were. Have you been ill or had any complications with your health since your last period? If so, please describe

Contraception Is this pregnancy a result of a contraceptive failure and if so what was used? Is there anything we can do to assist with your contraceptive needs?

Anything else Is there anything else the doctor should know about your health or do you have any special requests?