

Health History (page 1 of 2)

Please print this form, fill it out, and either fax it or bring it with you for your visit. Thank you!



Patient Name: _____ Date: _____

Please mark your answers carefully.

No Yes

1 Are you allergic to any medications?

If yes, please list: _____

Physician Notes: _____

2 Have you had any condition in the past?

- | | | |
|---|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Arthritis or Lupus |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Bowel Disease |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Recurrent Urinary Tract Infection | |

Describe, if needed: _____

Physician Notes: _____

3 Have you ever had surgery?

If yes, please list: _____

Physician Notes: _____

4 Are you having any health problems or symptoms at this time?

If yes, please list: _____

Physician Notes: _____

Exposures Affecting Health

No Yes

5 Do you smoke cigarettes? If yes, how many per day? _____

Physician Notes: _____

6 Do you drink alcoholic beverages? If yes, what kind and how often? _____

Physician Notes: _____

7 Please list any medications taken since your last period: _____

Physician Notes: _____

8 Please list any "recreational" drugs used since your last period (i.e. cocaine, marijuana, etc...): _____

Physician Notes: _____

9 Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?

If yes, what exposure? _____

Physician Notes: _____

10 Please list any sources of chemical or radiation exposure that you encounter: _____

Physician Notes: _____

11 If you are on a restricted diet, please describe: _____

Physician Notes: _____

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Health History (page 2 of 2)

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Patient Name: _____ Date: _____

Please mark your answers carefully.

Gynecologic Health History

No Yes

12 When was your last Pap Smear? Date: _____

Have you ever had an abnormal Pap Smear?

If yes, were you treated? _____

What was the diagnosis? _____

Physician Notes: _____

13 Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease?

If yes, when and where were you treated? _____

Physician Notes: _____

14 Have you ever had Herpes?

Physician Notes: _____

15 Have you ever used an IUD (intrauterine device) for contraception?

If yes, when and where were you treated? _____

If yes, please indicate when: _____

Did you have any problems? If so, please describe: _____

Physician Notes: _____

16 Do you have a history of infertility?

If yes, please describe when and treatment received: _____

Physician Notes: _____

17 Please list any other concerns you have related to your past health history:

Physician Notes: _____

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Patient Signature

Date

Family History and Genetic Screening

Please print this form, fill it out, and either fax it or bring it with you for your visit. Thank you!



Patient Name: _____ Date: _____

Please mark your answers carefully. The first column usually indicates family history negative for the genetic problem, while the second column indicates an area of possible concern to be discussed with the doctor.

No Yes

1 Have either you or the baby's father had a child born with a birth defect?
If yes, please describe: _____

2 Did either you or the baby's father have a birth defect yourselves?
If yes, please describe: _____

3 Please describe any abnormalities that have occurred in children in your family or the baby's father's family. For example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis:

4 Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)?
If yes, have either of you had genetic counseling? Yes No
If yes, have either of you had chromosomal studies? Yes No
Where and what were the results? _____

5 Some genetic problems occur more often in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father in one of these backgrounds:
 Jewish ancestry? If yes, have you had Tay-Sachs screening? Date: _____ Results: _____
 Black ancestry? If yes, have you had Sickle Cell screening? Date: _____ Results: _____

6 Please mark if anyone in your family or the baby's father's family has:
 Diabetes If yes, how is that person related to you? _____
 Bleeding Disorder If yes, how is that person related to you? _____
 Hypertension If yes, how is that person related to you? _____

7 Please list any other concerns you have about birth defects of inherited disorders:

8 Will you be 35 or older at the time the baby is born?
 9 Will the father be 50 or older?

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