

MIDWEST MATERNAL-FETAL MEDICINE  
621 South New Ballas Road, Suite 2007-B  
St. Louis, Missouri, 63141  
Phone: 314-991-5000 Fax: 314-991-5035

**CONFIDENTIAL HEALTH HISTORY**

Please write in your name and date of birth on each page. This form is separated & filed in different areas of your medical record. It is important that this information is documented on each page. Thank you.

DATE: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS # \_\_\_\_\_

Marital Status: \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Widowed \_\_\_\_ Divorced/Separated

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact (Relationship): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Father of Baby: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you live with the baby's father? \_\_\_\_ If no, who do you live with? \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Your Religion (Optional): \_\_\_\_\_ Father's Religion (Optional): \_\_\_\_\_

Your Ethnic Origin: \_\_\_\_\_ Father's Ethnic Origin: \_\_\_\_\_

**MENSTRUAL HISTORY**

1<sup>ST</sup> day of last menstrual period: \_\_\_\_\_ Are periods regular:  Yes  No

Frequency: \_\_\_\_\_ On birth control at time of conception  Yes  No

Date of 1<sup>st</sup> Positive Pregnancy Test: Urine: \_\_\_\_\_ Blood: \_\_\_\_\_



Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**GYNECOLOGICAL HISTORY**

Yes	No		Details/Include Diagnosis, Date, Treatment
		Most recent PAP smear	
		Abnormal PAP smear	
		Disorders of the uterus, ovaries or fallopian tubes.	
		Disorders of the breast	
		Infertility	
		Did your mother take DES while pregnant with you?	

**MEDICAL HISTORY**

Yes	No	Circle applicable items	Details, include diagnosis, date, treatment
		Diabetes	
		High blood pressure	
		Heart disease	
		Autoimmune disorder	
		Kidney disease/frequent urinary tract infection	
		Neurologic/seizure disorder	
		Severe headaches or migraines	
		Psychiatric disorders	
		Hepatitis A, B or C or other liver disease	
		HIV positive	
		Varicosities, phlebitis, blood clot	
		Thyroid dysfunction	
		Exposure to trauma or violence	
		Blood transfusion	
		Rh sensitized	
		Tuberculosis or asthma	
		Seasonal allergies	
		Anesthetic complications	
		Cancer	
		Other	

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Please list any surgeries or hospitalization you have had in the past. Date

1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

**SOCIAL HISTORY**

YES	NO	
		Do you or have you recently smoked?
		If yes, how many cigarettes per day?
		Do you drink alcohol or have you consumed alcohol during pregnancy
		If yes, how many drinks per day?
		Do you use illicit or recreational drugs?
		If yes, type, amount & frequency:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**INFECTION HISTORY**

	YES	NO		YES	NO
Live with someone with TB or exposed to TB			History of gonorrhea, chlamydia, HPV, syphilis, trichomonas		
Patient or partner with history of genital herpes			Other		
Rash or viral illness since last menstrual period					

**FAMILY MEDICAL HISTORY**

	Age if Living	Age at Death	Cause of Death	List All Medical Problems
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
List Brothers and/or Sisters				

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**GENETIC SCREENING**

Include patient, baby's father or anyone in either family

	YES	NO
Patient's age > 35 as of estimated date of delivery		
Italian, Greek, Mediterranean or Asian background		
Neural tube defect (meningomyelocele, spina bifida or anencephaly)		
Congenital heart defect		
Down syndrome		
Tay-Sachs (i.e, Jewish, Cajun, French, Canadian)		
Canavan disease		
Sickle cell disease or trait		
Hemophilia		
Muscular Dystrophy		
Huntington's Chorea		
Cystic Fibrosis		
Mental Retardation/Autism. If Yes, was person tested for Fragile X?		
Maternal metabolic disorder (i.e., Type 1 Diabetes, PKU)		
Patient or baby's father had a child with birth defects not listed		
Recurrent pregnancy loss or stillbirth		

Comments: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Yes	No		Yes	No	
		<b>CONSTITUTIONAL:</b>			<b>BREASTS:</b>
		Unexplained weight change			Swelling
		Anorexia			Lumps
		Fatigue (always tired)			Pain
		Fever			Nipple discharge
		Sweating			Do you perform monthly breast exams?
		Chills			<b>CARDIOVASCULAR:</b>
		Insomnia			Chest pain or discomfort
		Irritability			Rapid or irregular heart beats
		<b>GENERAL:</b>			Loss of consciousness
		Heat intolerance			Numbness or tingling in extremities
		Cold intolerance			Peripheral nerve dysfunction
		Excessive thirst			Shortness of breath when lying flat
		Excessive hunger			Swelling in hands or feet
		<b>SKIN:</b>			Leg/calf pain or cramping
		Rashes			Heart murmurs
		Itching			<b>RESPIRATORY</b>
		Ulcers			Sleep disturbance due to breathing
		Sores			Coughing up blood
		Bruising			Excessive sputum
		Bleeding tendency			Cough
		<b>EYES:</b>			Chest discomfort
		Change in vision			Excessive snoring
		Glaucoma			Shortness of breath with exertion
		Family history of glaucoma			Wheezing
		Pain			<b>GASTROINTESTINAL</b>
		Redness			Excessive appetite
		Irritation			Heartburn
		Excessive tearing			Abdominal bloating
		Double vision			Abdominal pain
		Blind spot in visual field			Excessive belching
		Intolerance of light			Gas
		Discharge			Nausea
		<b>EARS/NOSE/THROAT</b>			Vomiting
		ringing in ears			Vomiting of blood
		Decreased hearing			Food intolerance
		Difficulty hearing			History of hepatitis
		Difficulty swallowing			History of jaundice (yellowish skin color)
		Ear discharge			Bloody stools
		Nasal congestion			Dark tarry stools
		Hoarseness			Change in bowel habits
		Earache			Diarrhea
		Nosebleeds			Constipation
		Sore throat			Hemorrhoids

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**CURRENT MEDICATIONS**

Name of Medication	Dose/Frequency	Date Started	For Office Staff Use

Name and phone number of pharmacy: \_\_\_\_\_

Allergies to medications:  Yes  No

If yes, please list medication and reaction:

Medication	Reaction

Allergy to Latex:  Yes  No

The information I have provided about my medical history is accurate to the best of my knowledge.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

R.N./M.A. Review:

\_\_\_\_\_  
R.N./M.A. Signature

\_\_\_\_\_  
Date

Physician Review:

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date