

Bryan S. Jick, MD, FACOG  
 Jennie J. Chang, MD, FACOG  
 Jennifer Y. Park, MD, FACOG  
 Diane K. Guerrero, RNC, WHNP  
 625 South Fair Oaks Avenue  
 Suite 255, South Lobby  
 Pasadena, CA 91105



Telephone 626.304.2626  
 Facsimile 626.585.0695  
 Voicemail 626.696.2688  
[www.fowh.com](http://www.fowh.com)  
[drjick@fowh.com](mailto:drjick@fowh.com)  
[drchang@fowh.com](mailto:drchang@fowh.com)  
[drpark@fowh.com](mailto:drpark@fowh.com)

*Thank you for answering all of the following questions. Your health is important to us. Congratulations!*

**NEW OBSTETRICS PATIENT HISTORY FORM**

TODAY'S DATE \_\_\_\_\_ Your age \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 YOUR NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_  
 Your spouse/partner's full name \_\_\_\_\_  
 REFERRED HERE BY \_\_\_\_\_

**1. CURRENT PREGNANCY**

What was the FIRST day of the last menstrual period? \_\_\_\_\_ Is this date definite? (Y/N) \_\_\_\_\_  
 Cycles regular? (Y/N) \_\_\_\_\_ Cycle length (avg=28 days) \_\_\_\_\_ Date of first pos. preg. test \_\_\_\_\_  
 Conception (check one): \_\_\_\_\_ normal Date of conception? \_\_\_\_\_ IUI (date \_\_\_\_\_)  
 \_\_\_ IVF fresh cycle (date of egg retrieval \_\_\_\_\_) \_\_\_ IVF frozen embryo (Date of embryo transfer \_\_\_\_\_)  
 What was your weight just before becoming pregnant? \_\_\_\_\_ What is your height? \_\_\_\_\_  
 When was your last pap smear? \_\_\_\_\_ By whom? \_\_\_\_\_ Was it normal? YES NO

**2. PAST PREGNANCY DETAILS**

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Date of Delivery	# weeks at Delivery	Length of Labor	Birth Wght.	M F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location

### 3. PATIENT MEDICAL HISTORY

*(If YOU have EVER had any of these conditions, please indicate)*

X if YES	Condition	Comments
	<b>1. Diabetes</b> (type 1, type 2, previous gestational diabetes. List any medicine you are on now or in the past):	
	<b>2. Hypertension</b> (high blood pressure now or in the past):	
	<b>3. Heart Disease</b> (fainting, heart murmurs, abnormal rate or rhythm, prior heart attack, abnormal valves):	
	<b>4. Autoimmune Disorder</b> (Lupus, Rheumatoid Arthritis, Fibromyalgia or other related conditions):	
	<b>5. Kidney Disease or Urinary Tract Infections</b> (recurrent UTI, kidney stones):	
	<b>6. Seizure Disorder or Neurologic Disease</b> (migraines, epilepsy, history of TIA or stroke):	
	<b>7. Mental Health Condition</b> (includes anxiety or panic attacks, OCD, bipolar disorder, eating disorder):	
	<b>8. History of Depression or Postpartum Depression</b> (mild or severe, suicide attempts, hospitalization ever):	
	<b>9. Gastrointestinal or Liver Disease</b> (irritable bowel syndrome [IBS], Crohn's Disease, Ulcerative Colitis,):	
	<b>10. Varicose Veins or Blood Clots in Veins</b> (pulmonary embolism, DVT – deep vein thrombosis):	
	<b>11. Thyroid Disease</b> (under or over active thyroid, thyroid cancer or radiation):	
	<b>12. Domestic Violence</b> (now or ever in the past):	
	<b>13. History of Blood Disorders or Transfusion</b> (anemia, blood clotting problem, transfusion ever):	
	<b>14. Smoking History</b> (current or former smoker):	
	<b>15. Alcohol Use History</b> (current or past use or abuse of alcohol):	
	<b>16. Illicit or Recreational Drug Use History</b> (current or past use or abuse):	
	<b>17. Rh Disease or Rh Negative</b>	
	<b>18. Lung Disease</b> (asthma, chronic bronchitis, TB):	
	<b>19. Seasonal Allergies</b> (hay fever, asthma):	
	<b>21. Breast Disease or Breast Surgery</b> (implants above the muscle, under the muscle, reduction):	
	<b>23. Complications of Anesthesia</b> (describe):	
	<b>25. History of Abnormal Pap Smear</b> (any treatments such as freezing, LEEP or cone biopsy and when):	
	<b>26. History of Uterine Abnormality</b> (double uterus, unicornuate uterus):	
	<b>27. History of Infertility or IVF, IUI, insems?</b>	

\*Note – some numbers are skipped due to this data being entered into the EMR

#### 4. SURGERY or HOSPITAL ADMISSIONS

Surgery or Hospital Admission - Details	Year

#### 5. SYMPTOMS SINCE BECOMING PREGNANT

*(Are you currently experiencing any of the following symptoms to a **significant degree?**)  
(If so, please indicate with an X)*

**General**

- Fatigue or Weakness
- Fever, Chills or Sweats
- Loss of Appetite

**Urinary**

- Burning with Urination
- Leakage of Urine
- Waking at night 2 or more times

**Eyes, Ears, Nose and Throat**

- Nose Bleeds
- Sore Throat
- Vision or Hearing Changes

**Skin**

- Itching
- Moles or Sores
- Rash

**Breasts**

- Breast Lump
- Breast Pain or Tenderness
- Nipple Discharge (other than white)

**Neurologic**

- Dizziness
- Headaches
- Migraines
- Memory Problems

**Cardiovascular**

- Chest Pain
- Irregular Heartbeat or Palpitations

**Musculoskeletal**

- Joint Pain (Back, Knee, Wrist, Hip)
- Joint Swelling
- Muscle Cramping or Pain

**Respiratory**

- Chronic Cough
- Shortness of Breath
- Wheezing

**Psychological**

- Anxiety, Worries, Stress (Excessive)
- Depressed
- Feeling Out of Control

**Gastrointestinal**

- Diarrhea (watery stool)
- Heartburn
- Nausea or Vomiting
- Severe Constipation

**COMMENTS**

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## 6. GENETIC SCREENING

(If you or ANY close relative of yours - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please CIRCLE YES)

1. IS PATIENT GOING TO BE AGE 35 BY THE DUE DATE?	YES	NO
2. HISTORY of THALASSEMIA or HEMOGLOBIN DISORDER	YES	NO
3. HISTORY of NEURAL TUBE DEFECT (spina bifida)	YES	NO
4. HISTORY of CONGENITAL HEART DEFECT	YES	NO
5. HISTORY of DOWN SYNDROME	YES	NO
6. &7. IS THE MOTHER OR FATHER OF THE BABY ASHKENAZI JEWISH or CAJUN? If yes, has any genetic testing been done?	YES Yes	NO No
8. HISTORY of SICKLE-CELL ANEMIA or SICKLE-TRAIT	YES	NO
9. HISTORY of HEMOPHILIA	YES	NO
10. HISTORY of MUSCULAR DYSTROPHY	YES	NO
11. A. HISTORY of CYSTIC FIBROSIS B. IS THE MOTHER or THE FATHER OF THE BABY CAUCASIAN/EUROPEAN? If yes, has any Cystic Fibrosis carrier testing been done?	YES YES Yes	NO NO No
12. HISTORY of HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA)	YES	NO
13. HISTORY of MENTAL RETARDATION If yes, was testing for Fragile X chromosome done?	YES Yes	NO No
14. HISTORY of ANY INHERITABLE GENETIC SYNDROME or ANY BIRTH DEFECTS	YES	NO
15. HISTORY of MATERNAL PKU OR OTHER METABOLIC SYNDROME	YES	NO
16. PATIENT OR BABY'S FATHER HAD A CHILD WITH ANY BIRTH DEFECTS	YES	NO
17. HISTORY OF STILLBIRTH OR 2 OR MORE MISCARRIAGES	YES	NO
18. ANY HISTORY OF ILLICIT DRUG USE SINCE LAST MENSTRUAL PERIOD	YES	NO

## 7. PRESCRIPTION MEDICATIONS YOU ARE TAKING

List name of medication, dose, and reason

## 8. DRUG STORE MEDICATION, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

List name of product and dosage

Pharmacy Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Fax # \_\_\_\_\_

**ALLERGIES (circle choices)**

Do you have any known allergies? NO ALLERGIES

Allergic to Latex? YES NO

*If yes, please list all allergies and your allergic reaction*

Allergic to	Reaction

**9. INFECTION HISTORY**

1. DO YOU LIVE WITH SOMEONE WHO MIGHT HAVE TUBERCULOSIS?	YES NO
2. DO YOU or YOUR PARTNER HAVE A HISTORY OF GENITAL HERPES?	YES NO
3. HAVE YOU HAD A SKIN RASH or VIRAL ILLNESS SINCE YOUR LAST PERIOD?	YES NO
4. HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS B OR C ?	YES NO
5. HAVE YOU EVER HAD GONORRHEA, SYPHYLLIS, CHLAMYDIA, HIV or VENEREAL WARTS? (circle any that apply)	YES NO
6. DO YOU OR YOUR PARTNER HAVE A HISTORY OF A BLOOD TRANSFUSION OR A HISTORY OF IV DRUG USE?	YES NO

**10. FAMILY MEDICAL HISTORY**

*(If ANY close relative of yours - such as maternal and/or paternal grandparents, parents, brothers, and sisters – has EVER HAD or CURRENTLY HAS any of the problems listed below.*

CONDITION	Please <u>CIRCLE CONDITION</u> and indicate who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, STROKE	
3. TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE	
4. BREAST DISEASE, BREAST CANCER	
5. STOMACH, GI or COLON DISEASE or CANCER	
6. KIDNEY DISEASE, KIDNEY STONES	
7. GYN DISEASES, OVARIAN CANCER, UTERINE FIBROIDS	
8. MUSCULOSKELETAL DISEASE, OSTEOPOROSIS	
9. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
10. SEVERE DEPRESSION or OTHER PSYCHIATRIC CONDITION	
11. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
12. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
13. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	
14. ANY TYPE of CANCER or MALIGNANT TUMORS	

## 11. ADDITIONAL PREGNANCY ISSUES

1. It is now advised to screen all pregnant women for the HIV virus. This will be added to your initial prenatal labs unless you tell us not to	OK	NO	TALK TO ME
2. Have you heard about Nuchal Translucency testing for Down Syndrome? (We will discuss this during your first visits here)	YES	NO	MAYBE
3. Do you get 3 servings per day of dairy products? If not, we advise a daily Calcium Supplement (like CitraCal) with Vit D		YES	NO
4. Do you own any cats? If so, it is advised that pregnant women not change the cat litter		YES	NO
5. Are there any known or suspected hazards in your workplace? What is your occupation? _____	YES	NO	MAYBE
6. Do you have plane trips planned during this pregnancy? If so, we generally advise not flying after 32 weeks gestational age	YES	NO	MAYBE
7. In the past year, have you been threatened, hit, slapped or kicked by anyone you know or do you feel unsafe where you live?	YES	NO	TALK TO ME
8. Do you use a seat belt 100% of the time while driving?		YES	NO
9. Are you considering having a tubal ligation (permanent sterilization)?	YES	NO	MAYBE
10. If you have a boy, do you want him circumcised?	YES	NO	MAYBE
11. Do you plan to breast feed after delivery?	YES	NO	MAYBE
12. Have you ever had chicken pox? If not, have you been vaccinated or have you already tested immune?	YES	NO	MAYBE
13. Have you been vaccinated for whooping cough in the past 10 years (the vaccine is called TDaP or DTaP)?		YES	NO
14. Have you ever tested positive for vaginal Strep B or Group B Strep?	YES	NO	MAYBE
15. Do you plan to save the baby's umbilical cord blood at the time of delivery or would you like more information about this?	YES	NO	MAYBE
16. If you already have a Pediatrician, please enter their name. Is this doctor on staff at Huntington Hospital?	Dr. _____	YES	NO
17. Please see our OB guide on the web at: <a href="http://www.fowhobguide.com">www.fowhobguide.com</a>			

It is not necessary to have made all of the above decisions yet.  
We will discuss all pregnancy issues and your concerns at your consultation and throughout your pregnancy.  
The above list is to help you as you begin to explore some of these issues

**Notes or Questions for the Doctor:** \_\_\_\_\_

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