PATIENT NAME: ____ DATE FORM COMPLETED: ______ / ______ / ______

Past Medical History

	Yes	No	Year/Description
Epilepsy/Seizures	____	____	____
Other Neurological Disorders	____	____	____
Tuberculosis	____	____	____
Anemia	____	____	____
Sickle Cell	____	____	____
Heart Disease	____	____	____
Clots in Legs/Lungs	____	____	____
Kidney Disease	____	____	____
Headaches/Migraines	____	____	____
Thyroid Disorder	____	____	____
High Blood Pressure	____	____	____
Arthritis	____	____	____
Autoimmune Disorder (Lupus)	____	____	____
Depression/Postpartum Depression	____	____	____
Asthma	____	____	____
Diabetes	____	____	____
Recurrent Urinary Tract Infections	____	____	____
Hepatitis/Liver Disease	____	____	____
Herpes	____	____	____
Ulcers/Bowel Disease	____	____	____
History of blood transfusion	____	____	____
Rh (D) Sensitized	____	____	____
Seasonal Allergies	____	____	____
Breast Cancer	____	____	____
HIV	____	____	____
Chicken Pox	____	____	____

Are your immunizations up-to-date? Date of last tetanus___________

Family History

Have your parents, siblings or children had the following:

	Yes	No	Relation
Breast Cancer	____	____	____
Colon Cancer	____	____	____
Ovarian Cancer	____	____	____
Uterine Cancer	____	____	____
Recurrent miscarriage	____	____	____
Infertility	____	____	____
Diabetes	____	____	____
Endometriosis	____	____	____
Fibroids	____	____	____
Heart Disease	____	____	____
Kidney Disease	____	____	____
Depression	____	____	____
Other (Please explain)	____	____	____

Social History

Do you smoke? □Yes □No Have you ever smoked? □Yes □No

If so, how much?____________ For how long?___________________

Do you drink alcohol? □Yes □No How much?_________ How often?__________ What kind?____________

Do you or have you ever used recreational drugs? □Yes □No Please Describe________________________

Do you have a history of blood transfusion, IV drug use, multiple sexual partners or sexual exposure to a gay or bisexual person, exposure to an IV drug user, or have any other reason to believe you may have been exposed to AIDs?____

Please list any sources of chemical/radiation exposure that you have encountered:______________________

Do you exercise regularly? □Yes □No What type?_________________ How often?________________________

What is your average intake of caffeine daily (coffee, tea, soda)?______________________________________

If you are on a restricted diet, please describe:____

Gynecology History

At what age did you menstrual periods begin?_____________________________

Any abnormal bleeding? Please describe?________________________________

Do you have symptoms of premenopause?________________________________

Do you have pain or bleeding with intercourse?____________________________

Do you have sexual difficulty/discomfort in your relationship?____

When was your last mammogram?_____________________________

Have you ever had a biopsy of the breast performed?_____________ What was the result?________________

Have you ever had fibroid tumors?___________________ Ovarian cysts?_________________________

Have you ever been concerned about infertility? □Yes □No

If so, what tests/therapies have been done?____

Family Planning

Please check any method of contraceptive you have used in the past:

□ Birth Control Pills □ Condoms □ Depo-Provera/other injectable

□ IUD (Intrauterine Device) □ Diaphragm □ Withdrawal □ Spermicide

□ Patch □ Vaginal Ring □ Tubal Ligation □ Vasectomy

□ None □ Other (Describe:____)

Please check any method of Natural Family Planning you have used in the past:

□ None

□ Symptothermal (please circle: CCL Northwest Family Services)

□ Ovulation Method (please circle: Billings FAF Creighton)

□ Calendar/Rhythm

Which method do you currently use?____

Do you have any religious objections to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusion): □Yes □No If Yes, please indicate:______________________________

Review of Systems

(Check all that apply)

General
- □ Fatigue
- □ Weight Gain
- □ Weight Loss
- □ Fever
- □ Hot flashes

Endocrine
- □ Sensitivity to hot
- □ Sensitivity to cold
- □ Excessive thirst
- □ Abnormal hair growth
- □ Hair Loss

Neuro
- □ Headaches
- □ Seizures
- □ Loss of strength
- □ Loss of sensation

Skin
- □ Rash
- □ Moles (growth/change)
- □ Acne

Eyes
- □ Visual Changes
- □ Seeing spots or lights

ENT
- □ Sore Throat
- □ Nasal Congestion

Respiratory
- □ Cough
- □ Difficulty Breathing

Heart
- □ Chest pain
- □ Palpitations

Breasts
- □ Breastfeeding
- □ Mass or lump
- □ Nipple discharge
- □ Breast tenderness
- □ Perform self-breast
- □ Other

Gastrointestinal
- □ Abdominal Pain
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Heartburn
- □ Blood in stool

GYN
- □ Vaginal discharge
- □ Vaginal burning/pain
- □ Vaginal bulge
- □ Vaginal/vulvar itching
- □ Pelvic pain/pressure
- □ Abnormal bleeding
- □ Other__________________

Urology
- □ Painful/burning urination
- □ Blood in urine
- □ Leakage or loss of urine

Musculoskeletal
- □ Muscle pain
- □ Joint pain

Mood
- □ Depressed
- □ Anxiety
- □ Mood Swings

Hematology
- □ Easy bruising
- □ Frequent nosebleeds

I verify that the information I have provided is accurate to the best of my knowledge.

______________________________________ Patient Signature

______________________ Date

FAMILY HISTORY & GENETIC HISTORY

[Note: 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.]

Circle one

1. Have either you or the baby's father had a child born with a birth defect? **Yes** **No**
If Yes, please describe: ______________________________

2. Did either you or the baby's father have a birth defect yourselves? **Yes** **No**
If yes, please describe: ______________________________

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (i.e. mental retardation, birth defects, deformities, or inherited disease like hemophilia, muscular dystrophy, or cystic fibrosis.) ______________________________

____

____

How is the effected child/person related to you?______________________________

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? **Yes** **No**
If Yes, have either of you had genetic counseling? **Yes** **No**
If Yes, have either of you had chromosomal studies? **Yes** **No**
If Yes, where and results?______________________________

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father is of one of these backgrounds:

Jewish ancestry? **Yes** **No** If Yes, have you had Tay-Sachs screening tests? **Yes** **No**
Date: ____ /____ /____ Result: ________________

Black? **Yes** **No** If Yes, have you had Sickle Cell screening? **Yes** **No**
Date: ____ /____ /____ Result: ________________

6. Please indicate if anyone in your family or the baby's father's family has:

Diabetes	**Yes**	**No**	If yes, how is that person related to you? ____________
Bleeding Disorder	**Yes**	**No**	If yes, how is that person related to you? ____________
Hypertension	**Yes**	**No**	If yes, how is that person related to you? ____________
Cancer	**Yes**	**No**	If yes, how is that person related to you? ____________

7. Please list any other concerns you have about birth defects or inherited disorders: ______________________________

____

____

8. Will you be 35 or older at the time the baby is born: **Yes** **No**

9. Will the father be 50 or older? **Yes** **No**

______________________ ______________________ ______ / ______ / ______
Patient Name (Print) Patient Signature Date

PHYSICIAN NOTES ON GENETIC HISTORY: ______________________________

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