HENDERSON AND WALTON WOMEN'S CENTER, P.C.
PATIENT HISTORY

Physician: Select One *Office Location:* Select One

NAME _____ **AGE** _____

Please take a few minutes to complete this questionnaire, and plan to bring it with you for your scheduled **OB** appointment. ***If you have been receiving OB care at another facility, you will need to bring your prenatal records with you during this visit.**

1) Is this your first pregnancy? Y If not, how many times have you been pregnant? # miscarriages # preterm births # full term births ____

2) If this is not your first pregnancy, please list any complications with previous pregnancies: _____

3) For this pregnancy, have you had a positive pregnancy test in a medical facility? N
Will you bring the results with you? N

4) Please list the first day of your last menstrual cycle?

5) Prior to pregnancy, would you say you had a menstrual cycle once a month? N

6) Were you using anything for birth control when you became pregnant? N
If so, please explain or list:

7) Please help us with your medical history by answering the following questions:

A. Please list any illnesses that you have been diagnosed with: _____

B. Have you ever been diagnosed with hepatitis? N

C. Have you ever had chicken pox? N

D. Have you ever been treated for a sexually transmitted disease? N
If so, please list:

E. Have you had x-rays or exposure to radiation or chemicals during this pregnancy? N Please list:

F. Have you ever had a blood transfusion? N When? _____

G. Please list previous surgeries and dates: _____

H. Were you taking any medications/drugs, prior to finding out that you were pregnant? N Please list: _____

I. Please list any medications you are taking now: _____

J. Are you allergic to any medications? N Please list: _____

K. Do you smoke? N How much per day?

L. Do you drink alcohol? N How much?

M. Do you wear seatbelts? N Do you own any cats? N

8) Please list all of your immediate family members (ex. mother, father, siblings, grandparents) that have been diagnosed with the following:

Heart disease or stroke
Stroke
Diabetes
Seizure disorders
Thyroid problems
High blood pressure _____
Cancer _____
Kidney disease/stones _____
Tuberculosis _____
Other _____

SIGNED _____ **DATE** _____