



**San Ramon OB/GYN**  
 11030 Bollinger Canyon Road, Suite 250  
 San Ramon, California 94582  
 Phone: (925) 736-0110 Fax: (925) 736-0120

Dr. Joanne Vogel, MD, FACOG  
 Dr. Jennifer Grabenstetter, MD

## OBSTETRIC MEDICAL HISTORY

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_ Date Form Completed \_\_\_\_\_

### PERSONAL HEALTH HISTORY

1. Are you allergic to any medications?  Yes  No  
 If yes, please list: \_\_\_\_\_
2. Please mark any conditions that you have or have had in the past:
 

<input type="checkbox"/> Arthritis or Lupus	<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bowel Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Herpes
<input type="checkbox"/> Headaches	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Clotting Disorder
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually Transmitted Diseases

 Describe, if needed: \_\_\_\_\_  
 \_\_\_\_\_
3. Please indicate any operations or surgeries you have had: \_\_\_\_\_  
 \_\_\_\_\_
4. Please describe any health problems or symptoms you are having at this time: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
5. How many times have you been pregnant, including this current pregnancy? \_\_\_\_\_  
 How many children do you have? \_\_\_\_\_
6. Do you have any religious objections to any form of medical treatment (e.g. refusal of blood transfusion)?  Yes  No  
 If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_

### GENETIC HEALTH HISTORY

1. Have you or has 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?  Yes  No  
 If yes, please describe \_\_\_\_\_
3. Please describe any abnormalities that have occurred in children of your family or baby's father's family (e.g. mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Do 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 or had chromosomal testing?  Yes  No
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:
 

Eastern Europe Jewish Ancestry	<input type="checkbox"/> Yes <input type="checkbox"/> No
African American	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mediterranean Ancestry or Southeast Asian Ancestry	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Please list any other concerns you have about birth defects or inherited disorders:  
 \_\_\_\_\_  
 \_\_\_\_\_
7. Will you be 35 years or older at the time the baby is born?  Yes  No
8. Will the father be 50 years or older?  Yes  No

**EXPOSURES AFFECTING HEALTH**

- 1. Do you use tobacco?  Yes  No If yes, how many packs per day \_\_\_\_\_
- 2. Do you drink alcoholic beverages?  Yes  No If yes, how often? \_\_\_\_\_ What type of drinks? \_\_\_\_\_
- 3. Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and herbal medicines: \_\_\_\_\_  
\_\_\_\_\_
- 4. Please list any illicit or recreational drugs used since your last period (e.g. cocaine, marijuana): \_\_\_\_\_  
\_\_\_\_\_
- 5. Do you have any reason to believe you may have been exposed to AIDS (e.g. history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to gay or bisexual male, exposure to an intravenous drug user)?  Yes  No
- 6. Do you work with chemicals or radiation (e.g. x-rays)?  Yes  No
- 7. Are you on a restricted diet?  Yes  No

**GYNECOLOGICAL HEALTH HISTORY**

- 1. When was your last Pap test? \_\_\_\_\_
- 2. Have you ever had an abnormal Pap test?  Yes  No  
If yes, when and how were you treated? \_\_\_\_\_
- 3. Have you ever had  gonorrhea,  chlamydia or  pelvic inflammatory disease?  Yes  No  
If yes, when and how were you treated? \_\_\_\_\_
- 4. Have you ever had herpes?  Yes  No  
If yes, how often do you have outbreaks? \_\_\_\_\_
- 5. Have you been treated for infertility?  Yes  No  
If yes, please describe when and treatment received? \_\_\_\_\_  
\_\_\_\_\_
- 6. Do you have any other concerns related to your past health history?  Yes  No  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

**PSYCHOSOCIAL SCREENING**

- 1. Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?  Yes  No
- 2. Do you feel unsafe where you live?  Yes  No
- 3. In the past 2 months, have you used any form of tobacco?  Yes  No
- 4. In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?  Yes  No
- 5. In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?  Yes  No
- 6. Has anyone forced you to perform any sexual acts that you did not want to do?  Yes  No
- 7. On a scale of 1 – 5, how do you rate your current stress level? Low 1 2 3 4 5 High
- 8. How many times have you moved in the past 12 months? \_\_\_\_\_
- 9. If you could change the timing of this pregnancy, would you want it:  
 Earlier  Later  Not at all  No Change

_____ Patient Signature	_____ Print Name	_____ Date
----------------------------	---------------------	---------------