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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. Do you or any family member have a history of problems with anesthesia? Yes No
 If yes, please describe _____
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 _____

PERSONAL 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 at 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
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