

Perinatal Associates of Sacramento
Initial History and Physical

Patient Name: _____ Date of Birth: _____ Age: _____

Marital Status: M S Home Address: _____

Home Telephone: _____ Work Telephone: _____

Husband's Name: _____ Age: _____ Work Telephone _____

PATIENT'S HISTORY (PAST-PRESENT)

Patient's History and Physical Date: _____

	Yes	No	Unknown
1. When was the first day of your last period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Was your period normal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get headaches more than once a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you having any problems urinating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had an illness with fever since your last period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you experienced vaginal bleeding with this pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you having any vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you used birth control pills within 3 months of getting pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had syphilis or gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have/Are you under the care of another physician with this pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list the physician's name _____			
13. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you use any street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you experienced domestic violence, sexual abuse or fearful of your safety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you been exposed to any toxic chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you taken any medicines since your last period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, please list them _____			
19. Have you had a problem getting pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. What is your height?			_____
21. What was your weight at the time of your last period?			_____
22. During any past pregnancy did you have any of the following?			
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toxemia (pre-eclampsia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you have asthma or any other lung problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you have any problem with your eyes other than needing glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever had vein inflammation or blood clots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever had seizures or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have bladder infections or kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have any problems with your stomach or bowels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you had blood in your stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you had any breast problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you have any blood or clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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33. Have you ever had hepatitis or any other liver problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you ever received a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Are you allergic to any medicines or anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which ones _____			
36. Have you had any surgeries? If so, what _____			
37. Have you been hospitalized for anything not mentioned above? If so, what _____			
38. Do you work with medical or dental patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Do you work with institutionalized patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Who lives in your household with you? _____			

FAMILY ILLNESS HISTORY

Have you, the baby's father, your children or blood relative had any of the following: Also include members of immediate family who are deceased.

	Yes	No	Unknown
1. Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Muscle diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. T.B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. A birth defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Twins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENETIC HISTORY

The following questions will help us to give you better care. With the help of your answers we can better recognize some possible problems and help us evaluate the health of your baby.

	Yes	No	Unknown
1. Will you be age 35 or older when the baby is due?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or the baby's father or another family member had a previous child with Down syndrome (mongolism)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Were you or the baby's father or any family member born with spina bifida, moningomyelocele (open spine) or anencephaly (no brain)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you or the baby's father have a birth defect or have you had a child born dead or alive with a birth defect not listed in the above questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a family history of male relatives with:			
hemophilia (bleeding disorders)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Certain genetic disease are more common in certain ethnic groups.			
Are you or the baby's father of Eastern Europe Jewish descent (Ashkenazi Jews)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have either of you been screened for Tay-Sach's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you or the baby's father of Black ancestry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have either of you been screened for Sickle-cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you or the baby's father of Asian, Italian, Greek, Sicilian, Pacific Island or Hatian descent? If so, circle which one.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are there other known genetic or chromosomal disorders in the family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you taken any of the following drugs during this pregnancy: Seizure medications, alcohol, smoke, anti-cancer drugs, anticoagulants or lithium? If so, <u>please circle</u> .			

Informant/Patient Signature

Date