Label

PREGNANCY TEST

MEDICAL HISTORY

SURGICAL HISTORY

Have you had any female surgery? Yes No *If so, what type? (check below):*

Breast☐	Hysterectomy☐	D&C☐	Ectopic pregnancy☐	Fibroids☐
Ovary☐	Laparoscopy☐	Cesarean section☐	Laser LEEP/Cryo of cervix☐	Other☐

Reason for Surgery / Findings: _____

Please list any other surgery *(i.e. appendectomy, heart surgery)*: _____

MEDICAL HISTORY

Check if you have had:

Cancer☐	High blood pressure☐	Anemia or blood clotting / bleeding problems☐
Arthritis or Lupus☐	Heart disease☐	Thyroid problems☐
Alcoholism☐	Diabetes☐	Digestive problems/ Eating disorder☐
Drug addiction☐	High cholesterol☐	Tuberculosis☐
Hepatitis☐	Blood transfusion☐	

GENETIC HISTORY

Did you or the baby's father have? A birth defect☐ Genetic counseling or testing☐

Have you or the baby's father had a child born or a family member with:

Birth defects☐ Deformities☐

Inherited diseases ☐*(such as muscular dystrophy, cystic fibrosis, sickle cell disease or trait)*

SOCIAL HISTORY

(Circle one) M S D W Relationship with spouse/partner?

Occupation: _____ Education: High School College Other

How many times have you moved in the past 12 months? _____

Substance use:	Alcohol ☐	*How often?*
	Tobacco ☐	*How man packs per day?*
Other:	*Marijuana* ☐	*How often?*
	Cocaine ☐	*How often?*
	IV Drugs☐	*How often?*

Exposure to domestic violence or abuse: Physical☐ Emotional☐ Sexual☐

REVIEW OF SYSTEMS

Please check if you have had problems with any of the following:

Genital/Urinary

Vaginal warts☐	Heavy vaginal bleeding☐	Painful intercourse☐	Urination at night☐
Vaginal dryness☐	Irregular vaginal bleeding☐	Urinary urgency☐	Bladder control/leakage☐
Pain/burning with urination☐	Gonorrhea☐	Painful menstrual periods☐	Other☐
Herpes☐	Vaginal warts☐	HIV☐	

Endocrine

Fatigue☐	Hair loss☐	Absence of menstrual periods☐
Hot flashes☐		

Skin / Breast

Nipple discharge☐	Sore that does not heal☐	Changes in mole☐
Rashes/persistent itching☐	Breast lumps/tenderness☐	

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Neurological
Frequent headaches☐ Poor coordination☐ Muscle weakness☐ Trouble sleeping☐

Psychiatric
Depression☐ Anxiety☐ Counseling or treatment☐ Mood swings☐
Suicidal ideas/attempts☐ Homicidal ideas/attempts☐

ENT
Visual problems☐ Allergies/hay fever☐ Frequent sore throat☐ Mouth ulcers☐
Hearing loss☐ Hoarseness☐ Sinus problems☐

Digestive
Heartburn☐ Rectal☐ Diarrhea☐ Yellow jaundice☐
Vomiting ☐ Black stools☐ Significant weight change☐ *(i.e., < or > 10-15 pounds/year)*

Cardiovascular
Chest pain☐ Irregular heartbeat☐ Fainting/dizziness☐ Mitral valve prolapse☐
Other heart problems☐

Respiratory/ Pulmonary
Shortness of breath☐ Coughed blood ☐ Wheezing☐

VACCINATION HISTORY

	YES	NO	UNSURE	Last Dose
Measles, mumps, rubella (MMR) ……	☐	☐	☐	
Tetanus/Diphtheria (TD) …….	☐	☐	☐	
Varicella or case of chickenpox ……	☐	☐	☐	
Influenza "flu" ……...	☐	☐	☐	
Pneumococcus "pneumonia" …… ……	☐	☐	☐	
Menactra…… …..	☐	☐	☐	

Review with patient by

Signature/Title/Date: _____

Signature/Title/Date: _____

Signature/Title/Date: _____

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